FRAMEWORK FOR STATE EVALUATION OF CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

State/Territory: **STATE OF CONNECTICUT**
(Name of State/Territory)

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

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(Signature of Agency Head)

Date: 3/31/2000

Reporting Period:

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SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

According to data dated November 10, 1999 from the U. S. Census Bureau, there were 57,000 uninsured children under 19 years of age in Connecticut with incomes at or below 200% of the federal poverty level (FPL) during the 1996, 1997, and 1998 period. A copy is attached. Connecticut's 1998 annual report provided an estimated baseline of 53,000 Connecticut children with incomes at or below 185% of the FPL. See attached copy. Please note that the 1999 Current Population Survey (CPS) estimate for 1996,1997, and 1998 is actually an average of the percent uninsured with incomes at or below 200% of FPL for each of those years applied to an estimate of the total population of 907,000 children under 19. The 1996, 1997, and 1998 estimate of 6.3% has a standard error associated with it of 1.7. The 1998 annual report presumably relied on the CPS estimate of 53,000 uninsured Connecticut children with incomes at or below 200% of FPL in 1993, 1994, and 1995, or 6.2% of a population of 849,000. The standard error of the 1993, 1994, and 1995 percentage estimate was 1.8. Thus, it is not possible to ascertain a significant difference between the two estimates since their 95% confidence levels clearly overlap to a considerable degree. The percent of children uninsured probably did not change, but the number of uninsured children seems to have changed because of an increase in population in the designated age groups.

1.1.1 What are the data source(s) and methodology used to make this estimate?

The CPS estimate of November 10, 1999. The 1998 and 1999 baseline estimates are based on the CPS estimates for periods before Connecticut implemented its SCHIP program. Connecticut's SCHIP was implemented on July 1, 1998. The 1998 baseline of uninsured children with incomes at or below 200% of FPL aggregated the 1993, 1994, 1995 period. The November 1999 estimate aggregated the period of 1996, 1997, and 1998. Each year's survey was conducted in March.

Thus, even the 1998 portion of the CPS estimate antedated the implementation of Connecticut's SCHIP.

1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Connecticut's Office of Health Care Access (OHCA) carried out a survey of health insurance coverage in 1995. The study was released in 1998 and a copy is attached. The survey was conducted during June through October of that year and asked over 2,000 families, stratified to oversample both families with Medicaid beneficiaries and families with uninsured members, about their health insurance coverage during the prior twelve months. OHCA's survey turned up an estimate that approximately 5.7% of Connecticut's children with incomes up to 185% of FPL were uninsured. For children aged 1 to 19 years the OHCA 95% confidence interval has a lower bound of 1.3% and an upper bound of 8.0% for 1995.

OHCA plans to follow up its 1995 household survey in the next year or two. In the interim, OHCA adopted a methodology used by the Florida Agency for Health Care Administration and analyzed the expected source of payment for hospital discharges of selected indicator conditions. This analysis cannot estimate coverage by income, but it seems to produce an estimate of the uninsured for the total population that is pretty close to the estimate produced by the population survey. That analysis indicated that the percentage of children, excluding newborns, under age 20, who were uninsured at the time of hospital admission for indicator conditions increased slightly between 1995 and 1997. That analysis would seem to agree with CPS's estimate of an increase in the uninsured rate during that period.

To quote many other studies of this nature, "further research is needed."

1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

Between October 1997 and March 2000, approximately 19,000 additional children under the age of 19 are receiving Medicaid coverage. As of 3/1/2000, HUSKY B enrollment has reached 5,006. In total, approximately 24,000 children have credible coverage as a result of Title XXI and Title XXI outreach efforts.

1.2.1 What are the data source(s) and methodology used to make this estimate?

For Medicaid, the source is the Department's Eligibility Management System. Medicaid managed care enrollment (HUSKY A) reports were used to calculate the estimated increase in Medicaid enrollment for children under 19 years of age. For HUSKY B (SCHIP), the enrollment data was obtained from Benova's eligibility system (BESSTB).

1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

The HUSKY B enrollment data represents the actual number of children enrolled in HUSKY B. The increase in Medicaid enrollment numbers represent an increase in the number of children enrolled in Medicaid managed care, therefore, it underestimates the number of children actually eligible for Medicaid. Approximately between 2,000 and 3,000 additional children are Medicaid eligible in any given month than are enrolled in managed care. This differential is due to the children who have been newly made eligible for Medicaid but have not yet enrolled in managed care. These children receive healthcare services through the standard Medicaid fee-for-service arrangement with providers.

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
9.1.1 To increase the number of children in Connecticut with health insurance by expanding Medicaid (HUSKY Part A) coverage and creating a new health insurance program for previously uninsured children, to be know as HUSKY Part B.	**9.2.1** To increase the number of children covered by health insurance.	Data Sources: The CPS estimate of November 10, 1999. The data source for enrollment in HUSKY A (Medicaid) is Connecticut's Eligibility Management System (EMS). The data source for enrollment in HUSKY B is Benova, the SPES. Methodology: At present there is no CPS data available during the time frame in which HUSKY B was implemented. Numerator: Total number of uninsured children in Connecticut Denominator: Total number of Connecticut children whose income falls below 200 percent of the federal poverty level. Progress Summary: As of 10/1/99 greater than 20,000 children now have insurance than before, thereby reducing the number of uninsured by greater than 20,000. (As of 3/1/00, 15,000 Medicaid and 5006 HUSKY B SCHIP).
9.1.2 To maximize participation in HUSKY, Parts A and B through outreach, a single point of entry, presumptive eligibility, a simplified application process and annual enrollment.	**9.2.2.** To maximize participation in HUSKY Parts A & B.	Data Sources: CPS estimate of 11/10/99; EMS; SPES Methodology: N/A Numerator: N/A Denominator: N/A Progress Summary: **Outreach—**the HUSKY Healthcare Outreach Partnership. The Department of Social Services has initiated a multi-level public outreach campaign to inform parents about the availability of children's health coverage, in cooperation with the

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		Connecticut Children's Health Council and Project, Benova (eligibility and enrollment contractor), Infoline, state Medicaid Managed Care Council and other partners in the health and human services field. The DSS community-based outreach contracting initiative, providing $450,000 to ten outreach contractors, complements the Covering Connecticut's Kids initiative, funded by the RWJ Foundation and coordinated by the Children's Health Council. In the first 20 months of Connecticut's combined Medicaid/CHIP program, more than 19,000 applications (for more than 37,000 children) to the single point of entry servicer (Benova) have been generated by a wide variety of outreach measures. Additional applications have been received at DSS field offices. The HUSKY Plus Behavioral and HUSKY Plus Physical Centers have actively engaged in outreach within the community as well as the managed care organizations. The Department of Social Services conducted statewide outreach efforts to inform school nurses, social workers and psychologists of the HUSKY Program. Other outreach activities include partnering with the Department of Labor to provide HUSKY information to employees who are being affected by a layoff or company closing. The Department also conducted outreach to a number of constituents including employers, civic organizations, community based agencies, and families and other state and municipal agencies. **Single Point of Entry—**Eligibility for SCHIP (HUSKY B) and enrollment (HUSKY A & B) are processed by a single point of entry server, known as Benova. Benova also participates in outreach. (NOTE: Medicaid eligibility is processed by DSS.) **Presumptive Eligibility—**An incremental approach to presumptive eligibility for HUSKY A only, to ensure effective systems and formal eligibility determination backup, is planned to begin for HUSKY A by

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		September 2000. This gradual phase-in is expected to focus on school-based health centers. **Simplified Application Process**—Information and application forms are available though Infoline and Benova. Benova is able to conduct over the phone application screening and send a pre-printed (including information received over the phone) application to the applicant for verification of income and signature. Both Benova and Infoline offer toll free telephone numbers. A revised, more streamlined application form will be available for use in the near future. The revised application continues to be only 2 pages (2 sides) long. **Annual Enrollment--** See Table 1.3, pages 3-4. See Table 4.1.1
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
9.1.2 To maximize participation in HUSKY, Parts A and B through outreach, a single point of entry, presumptive eligibility, a simplified application process and annual enrollment.	**9.2.2** 1. Expand Medicaid (HUSKY Part A) enrollment of uninsured children 15-18 years old who are under 185% of the federal poverty level.	Data Sources: EMS Methodology: Unduplicated count of Medicaid Expansion recipients since 10/1/97. Numerator: N/A Denominator: N/A Progress Summary: During the period of 10/1/97 – 2/11/00, 10,996 children were enrolled in the HUSKY A expansion group.

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	9.2.2 2. Expand Medicaid (HUSKY Part A) enrollment of uninsured children under 15 years old who are under 185% of the federal poverty level.	Data Sources: EMS Methodology: Unduplicated count of Medicaid recipients under 19 who were not part of the expansion group since 10/1/97 Numerator: N/A Denominator: N/A Progress Summary: During the period of 10/1/97 – 2/11/00, 243,021 children *under the age of 19* were enrolled in Medicaid. These children were not part of the Medicaid expansion cited above. This number includes all children who were eligible and enrolled for Medicaid, regardless of age or income.

Table 1.3

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OBJECTIVES RELATED TO CHIP ENROLLMENT		
9.1.2 To maximize participation in HUSKY, Parts A and B through outreach, a single point of entry, presumptive eligibility, a simplified application process and annual enrollment.	**9.2.2** 3. Increase the number of insured children 18 or under who are between 185% and 300% of the federal poverty level.	Data Sources: SPES enrollment files Methodology: count of enrollment files Numerator: N/A Denominator: N/A Progress Summary: From 7/1/98 to 9/30/99, 4101 children have been enrolled in HUSKY B. Of this total, 3986 HUSKY B enrollees have an income that is between 185% and 300% of the federal poverty level (Income Bands 1 and 2), and are subsidized by SCHIP (**See Table 4.1.1**). An additional 115 enrollees have income which exceeds 300% of the federal poverty level (Income Band 3). These enrollees are not subsidized by SCHIP but pay premiums at the state-negotiated rate. ** As of3/1/00, total enrollment is 5006.
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE		

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
9.1.3 To promote the health of children through a health benefit package tailored to the health care needs of children, which includes comprehensive preventive services.	**9.2.3** To promote the health of children through a comprehensive health benefits package. **1.** Match or exceed the statewide average of the percentage of children in HUSKY Parts A and B who receive immunizations by age two.	**1. Immunizations:** **A. HUSKY A** Data Sources: Administrative Methodology: HUSKY A and HEDIS 1999 modified. Numerator: The number of members in the denominator who received the following immunizations. Calculate six numerators: DTP, OP/IPV, MMR, HIB, HEPB, and All Immunizations. Denominator: All children whose second birthday occurred during the reporting year, who were members of the plan as of their second birthday and who were continuously enrolled in the same plan for the 12 months immediately preceding their second birthday. Members who have had no more than one gap in enrollment of up to 45 days during the 12 months proceeding their second birthday should be included in this measure. Progress Summary: During the reporting period, a total of 6054 2-year olds met the continuous enrollment criteria during the reporting period. Of that total, 77.07% received all required immunizations. Currently, the Connecticut average for immunizations is 66.06%. The national average is 60.99%, and the New England average is 73.06%. These last three measures are for all commercial health plans, which reported their data to the HEDIS program of the National Committee for Quality Assurance (NCQA). Not all plans reported their data to NCQA. The HUSKY A rate of immunization average currently exceeds state, regional and national averages

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		B. HUSKY B Data Sources: Hybrid Methodology: HUSKY A and HEDIS 1999, modified for HUSKY B Numerator: The number of members in the denominator who were identified through either administrative data or medical record review as having received each of the immunizations listed below. *See HUSKY A above*. Denominator: *See HUSKY A above*. Progress Summary: **HUSKY B:** While all the participating HUSKY B plans submitted data for this report, no members met the criteria to be included in the report. These specifications require review of services for time periods occurring before the implementation of and possible enrollment into the program. This information will be included in future reports. **2. Well-Child Visits:** **A. HUSKY A** Data Sources: Administrative Methodology: EPSDT Periodicity Schedule. In Connecticut, it is based on AAP and ACIP Guidelines. Numerator: The unduplicated number of individuals who received one or more comprehensive initial or periodic Well Child screens during the reporting period. Such screens must meet the definition contained in 42 CFR 441.56(b).
	2. Meet or exceed state standards for well-child care, with a goal of at least 80% of children receiving all recommended well-child visits.	

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		Denominator: All members of the plan for some time (no matter how brief) during the reporting period, ages birth through 20. Members are classified into age groups based on their age at the endpoint of the period covered by the report. Progress Summary: During the reporting period the total number of individuals eligible for EPSDT was 218,181. Of this group, 145,884 were eligible to receive at least one initial or periodic screening service (Screening ratio = 0.63). The total number of eligibles that actually received at least one initial or periodic screening service was 87,771 (Participation ratio = 0.56). These figures represent an increase of 5242 eligibles served, as compared to the previous reporting year. The participation ratio also improved from 53.84% to 60.16%, for a total increase of 6.32% from the previous year. **B. HUSKY B** Data Sources: Administrative, hybrid Methodology: HUSKY A, HEDIS Numerator: The unduplicated number of individuals who received one or more comprehensive initial or periodic Well Child screens during the reporting period. Denominator: All members of the plan for some time (no matter how brief) during the reporting period, ages birth through 18. Members are classified into age groups based on their age at the midpoint of the period covered by the report. Progress Summary: During the reporting period of October 1998 – June 1999, a total of 4078 HUSKY B enrollees were eligible for Well Child Visits. The total rate of recommended Well Child visits received

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		(screening ratio) was 0.63. The total rate of children receiving Well Child visits (participant ratio) was 0.56.

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OBJECTIVES RELATED TO HUSKY PLUS		
9.1.4. To assist those children enrolled in HUSKY B who have special physical and behavioral health care needs, to receive appropriate care through two supplemental plans (HUSKY Plus).	**9.2.4.** To assist children with special physical and behavioral needs through HUSKY Plus. 1. 100% of referrals to HUSKY Plus to have eligibility determinations within 21 days.	Data Sources: Administrative; medical records Methodology: Two HUSKY Plus Data Collection Tools (1 administrative, 1 medical record audit), as adapted from the HUSKY Plus Medical Record Audit Form. Numerator: Total # referrals which have documented eligibility determination within 21 days of referral date. Denominator: total number of referrals between 7/1/98 and 10/1/99 Progress Summary: An aggregate total of 55 children were referred to HUSKY Plus Behavioral (20) and HUSKY Plus Physical (35) during the specified time period. Of these children 41 (77.4%) were found eligible within 21 days of referral. There were 12(22.6%) referrals (3 HPP; 9 HPB) which exceeded the 21-day eligibility determination threshold. **See attached Data Compilation Sheet.**
9.1.4 continued	**9.2.4.** 2. Track the percentages of referrals to HUSKY Plus accepted or denied.	Data Sources: Same as above Methodology: Same as above Numerator: 1. Total # referrals accepted. 2. Total # referrals denied. Denominator: Total # referrals between 7/1/98 and 10/1/99. Progress Summary: An aggregate total of 46 (83.6%) referrals were accepted into the HUSKY Plus programs. HPP accepted 35 referrals (100% acceptance rate), while HPB accepted 11 referrals (52.7%

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		acceptance rate). HPB denied 9 referrals (45%). **See Table 2 for denial data.** Of those children who were enrolled in HPP or HPB, 13 (28.3%) were eventually disenrolled during the study period. HPP disenrolled 7(20%) children and HPB disenrolled 6(54.6%) children. On average, disenrolled children participated in the HUSKY Plus program an average of 8.25 months. **See Table 3 for disenrollment data.** **See attached data compilation sheets for Table 2 and Table 3.**
9.1.4 continued	**9.2.4.** 3. 100% of children with the following conditions will receive care according to individual needs and professional guidelines: • Cerebral Palsy • Cystic Fibrosis • Major Depression	Data Sources: Same as above Methodology: Same as above Numerator: Total # of HPP/HPB children with diagnosis of cerebral palsy, cystic fibrosis, and/or major depression Denominator: Total # of children enrolled in HPP/HPB. Progress Summary: In HPP one child had a diagnosis of Cystic Fibrosis and six children had a diagnosis of Cerebral Palsy. HPB also had one child with a diagnosis of Cerebral Palsy. Thus the total count for Cerebral Palsy is 7. Major Depression was diagnosed in 4 children, all of whom were enrolled in HPB. Thus a total of 12(26%) children enrolled in HPP and HPB were diagnosed with one of the targeted diagnoses. ➢ Cystic Fibrosis: There was only one child enrolled in HPP who had a diagnosis of Cystic Fibrosis. The GPC included the name of the specialist provider, and treatment protocols, which addressed special pulmonary and nutritional needs.

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		➢ Cerebral Palsy: Of a total of seven (6 HPP; 1 HPB) children with this diagnosis, 3 (50%) have access to specialized equipment that is required for mobilization. One of these children received funding from HPP for specialized equipment. ➢ Major Depression: Three of the four (75%) HPB children who were diagnosed with Major Depression received prescribed antidepressant medication and were evaluated by a licensed prescribing clinician at least monthly. However, in all three cases, monitoring for medication noncompliance was not specifically addressed in the medical record at the HPB/ Yale Child Study Center. Two (50%) of the children received individual and/or group therapy beyond that provided by HUSKY B. Two children (50%) received psychiatric in-home visits from HPB. There were no mobile crisis intervention services provided to this group.
9.1.5 To design the HUSKY Plus program in a way that will maximize coordination between the HUSKY B and HUSKY Plus, by integrating basic health care needs into the care provided for intensive health care needs and, whenever possible, building upon existing therapeutic relationships with Title V providers.	**9.2.5.** To maximize coordination between HUSKY B and HUSKY Plus. 1. 100% of children in HUSKY Plus who receive case management.	Data Sources: Same as above Methodology: Same as above Numerator: total # HPP/HPB enrollees who have documented case management services. Denominator: total # HPP/HPB enrollees Progress Summary: An aggregate total of 41(93.2%) of children enrolled in HPP and HPB receive case management services. HPB provided case management services to all enrolled children; HPP provided case management services to 30 (90.9%) children. The Lead Case Management Coordinator was identified for

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		30(90.9%) HPP children and 11 (100%) HPB children, for an aggregate total of 41 (93.2%). The HUSKY B MCO representative who was assigned to the case management team was identified for 28 (84.9%) HPP children and 10(90.9%) HPB children, for an aggregate total of 38 (86.4%). Global Plan of Care (GPC): A GPC was completed for 30(73.2%) of HPP and HPB children within 30 days of eligibility determination for HUSKY Plus. [HPP = 20(66.7%)/ HPB = 10 (90.9%)]. In all cases, the GPC included coordination with Individual Education Plans (IEP) and Individual Family Service Plan (IFSP), and other service entities. Progress notes in the medical record referred to the problems listed in the GPC, and indicated progress related to identified treatment goals. **See attached data compilation sheet.**
9.1.5 continued	**9.2.5.** 2. 100% of children in HUSKY Plus, who were formerly covered by Title V, who will continue to have the same specialty provider.	Data Sources: Same as above Methodology: Same as above Numerator: # HPP children who were formally covered by Title V who continue to have the same specialty provider. Denominator: # HPP children who were formerly covered by Title V. Progress Summary: In HPP only four enrollees had previous Title V services. Of these, two (50%) continued to use the same specialty provider(s). **See attached data compilation sheet.**

**** NOTE: Please refer to data compilation sheet for all HUSKY Plus figures. The completed annual HUSKY Plus Evaluation will be submitted when it is received.**

SECTION 2. BACKGROUND

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

X Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: ___HUSKY A – Medicaid expansion__

Date enrollment began (i.e., when children first became eligible to receive services): _____10/01/97_____

X Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program: ____HUSKY B_- SCHIP_____

Date enrollment began (i.e., when children first became eligible to receive services): _____7/01/98_____

___ Other - Family Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Employer-sponsored Insurance Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Wraparound Benefit Package

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other (specify) _____

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

2.1.2 **If State offers family coverage:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

N/A

2.1.3 **If State has a buy-in program for employer-sponsored insurance:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

N/A

2.2 What environmental factors in your State affect your CHIP program? (Section 2108(b)(1)(E))

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

Prior to the enactment of the HUSKY enabling legislation in October, 1997, Connecticut was already covering children born after September 30, 1983 with household incomes up to 185% of the federal poverty limit in the Medicaid program. In an effort to improve access to primary care and to control the double-digit inflation in Medicaid costs that the state experienced in the late 1980's, Connecticut implemented a mandatory

managed care program in October, 1995 that included these children, TANF families (formerly know as AFDC), pregnant women, and the child welfare population. By the fall of 1997 220,000 Medicaid recipients were enrolled in managed care. This included over 60% of all Medicaid recipients in the state and nearly all of the Medicaid eligible children. The only children not enrolled in managed care were these special needs children who were receiving services under the model waiver or from the Department of Mental Retardation.

The success of the expansion of Medicaid coverage for children positioned state policy makers to contemplate an even more comprehensive coverage for children with the advent of Title XXI. The challenge from Governor Rowland was to design a system that could potentially cover all the uninsured children in the state. With coverage already based on a rolling age cohort up to 185% FPL, the Title XXI limitation on expansion to 235% did not appear to offer that opportunity.

In the design of the Title XXI State Plan, the state took advantage of the provisions on income disregards to push eligibility up to 300% FPL. The major debate was whether such an expansion would be accomplished as a Medicaid expansion or as a combination of a Medicaid expansion and a state-designed program.

Concerns with a pure Medicaid expansion included: expansion of an entitlement program with an uncertain future for enhanced federal funding, expansion of the Medicaid mandates such as EPSDT, and an expansion of a population with recourse to legal cause of action under federal entitlement rules. The advantages of a state-designed benefit package included: expansion without entitlement, a benefit structure without coverage mandates, and the potential for future reform based on the flexibility of a commercial benefit structure. The expansion program, HUSKY B, includes cost-sharing requirements. Participants with household incomes above 235% FPL pay a monthly premium. Participants above 300% FPL pay the full-negotiated rate. All HUSKY B children are responsible for copayment up to an annual maximum. The cost sharing requirements were seen as a way to restrain state program costs and to foster a sense of personal responsibility for health care costs which is typical of the requirements placed on working families. All uninsured children are eligible to participate, although state and federal funds are used to subsidize the costs only for those children with household incomes below 300% FPL.

The final plan included an acceleration of Medicaid coverage up to 185%FPL for children up to their nineteenth birthday. For children in families with incomes from 185% to 300% FPL the stand-alone program known as HUSKY Part B was established. The benefit package for HUSKY Part B is extremely robust and included the best options for coverage from the three Health Maintenance Organizations that participate in the state employee insurance program.

The success of the Medicaid managed care program, now known as HUSKY Part A, was the basis for a full commitment to a managed care delivery system for the new state-designed program, HUSKY Part B. Unlike HUSKY A, HUSKY B has no fee-for-service delivery system. This decision did limit any choices for presumptive or retroactive eligibility in the new program. However, with the state-employee-based benefit structure the new program does lend itself to future opportunities for joint purchasing.

There was great concern that adverse selection would develop, especially among the first children to enroll in the new program. Advocates, who had supported a pure Medicaid expansion, expressed special concern about the adequacy of the state employee benefit package to deal with children with special needs.

In response to these concerns, the HUSKY Plus program was created to provide a supplemental benefit for children with special needs. The program was designed in two parts. HUSKY Plus Physical was an expansion of the existing Title V program for children with special needs. Eligibility for both Title V and HUSKY Plus was expanded up to 300% FPL and the diagnostic/functional criteria were liberalized. In addition, HUSKY Plus Behavioral was created to provide supplemental benefits for special needs children with behavioral health issues. Eligibility for both programs were limited to children with family incomes up to and including 300% FPL. Interestingly, preliminary treatment data on HUSKY B children appears to indicate that these children may be healthier than their HUSKY A counterparts. The low enrollment to date in HUSKY Plus is probably indicative of the fact that most children with special health care needs have already found a way into HUSKY A through the medically needy program, the model waiver, or the coverage groups associated with the Department of Children and Families. The department is studying the feasibility of allowing families with incomes above 300% FPL to buy-in to the HUSKY Plus program. Children who met the medical criteria for behavioral health would be allowed a hardship exemption to the six-month crowd out provision.

2.2.2 Were any of the preexisting programs "state-only" and if so what has happened to that program?

__ No preexisting programs were "state-only"
X One or more preexisting programs were "state-only" – Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?

In addition to the Title V program for special needs children, the state did offer a limited health insurance package to children in New Haven County with household incomes up to 200 % of the federal poverty limit. Known as the Healthy Steps program, this initiative never enrolled large numbers of children and was supported by 100% state funds. The children were rapidly transitioned to coverage under HUSKY and the program was phased out in 1999.

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that "affect the provision of accessible, affordable, quality health insurance and healthcare for children" (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects of your CHIP program.

X Changes to the Medicaid program

_ Presumptive eligibility for children
_ Coverage of Supplemental Security Income (SSI) children
X Provision of continuous coverage (12 months)
_ Elimination of assets tests
_ Elimination of face-to-face eligibility interviews
X Easing of documentation requirements

X Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify): working population - increase in number of non-cash cases

X Changes in the private insurance market that could affect affordability of or accesibility to private health insurance

- X Health insurance premium rate increases
- _ Legal or regulatory changes related to insurance
- X Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)
- _ Changes in employee cost-sharing for insurance
- _ Availability of subsidies for adult coverage
- X Other (specify): decrease in the availability of dependent coverage

X Changes in the delivery system

- X Changes in extent of managed care penetration (e.g., changes In HMO, IPA, PPO activity
- _ Changes in hospital marketplace (e.g., closure, conversion, merger)
- _ Other (specify)

_ Development of new health care programs or services for targeted low income children (specify)

X Changes in the demographic or socioeconomic context

- _ Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify)
- X Changes in economic circumstances, such as unemployment rate (specify): strong economy, decrease in unemployment rate
- _ Other (specify)

The most significant trend in the state since the implementation of Title XXI has been the impact on the Medicaid program. Through the use of the Single Point of Entry Servicer for both HUSKY A and B, the simplification of the application, the coordinated outreach campaign, and the attempt to de-stigmatize family Medicaid by marketing both Part A and B as "HUSKY," Medicaid has been transformed and improved as a result of Title XXI.

Through the combined effect of the Single Point of Entry Servicer (SPES) for application intake, the simplified application form, the coordinated outreach program, and other related efforts, the department enrolled 61,080 children under the age of 19 in the Medicaid (HUSKY A) program between July, 1998 and December, 1999. This IS evidence of the profound impact

that the public perception of the HUSKY Program has had on the target HUSKY A population.

Application activity in HUSKY B has been much more difficult to generate. Between 6/1/98 and 12/31/99 the SPES received 17,058 applications for HUSKY B. We are continuing to examine how our approach could be modified to attract applications from individuals with higher household incomes. We have intentionally resisted any attempt to separate the message concerning HUSKY B for fear of leaving behind the Medicaid population or conveying the impression that enrollment in HUSKY A is somehow less desirable. HCFA should note that there are individuals who do not want to apply for Medicaid once an economic screening of their application indicates that they are eligible for HUSKY A not HUSKY B. Other factors that may be limiting HUSKY B applications include crowd out and the impact of a booming economy. An option to purchase dependent coverage for HUSKY B eligibles through their employers could go along way towards resolving this problem. Federal rules are not user friendly on this point.

Finally, with the implementation of an integrated HUSKY program that includes the insurance model in HUSKY B, the state is well positioned to take the next step into coordinated health care purchasing. The contracts for HUSKY A, HUSKY B and state employees are all scheduled to end on June 30, 2001 with a one year extension option. This was not a matter of coincidence. We are currently studying the feasibility of a joint procurement in SFY 2002 that would provide the state with additional leverage with the Managed Care Organizations. It will also allow the state to begin to shape quality improvement in healthcare delivery on a much larger scale, one that is consistent with the expansion under Title XXI beyond the traditional Medicaid eligible population.

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery systems, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter 'NA".

Table 3.1.1		
	Medicaid CHIP Expansion Program **HUSKY A**	State-designed CHIP Program **HUSKY B**
Geographic area served by the Plan (Section 2108(b)(1)(B)(iv)	Statewide	Statewide
Age	Up to age 19	Up to age 19
Income* **Definition of family size and income, need more clarification**	Total family income must be equal to or less than 185% of the Federal Poverty Level	Total family income must be greater than 185% ,but not exceed 300% of the Federal Poverty Level.
Resources (including any standards relating to spend downs and dispositions of resources)	N/A	N/A
Residency requirements	Must be a resident of the State.	Must be a resident of the State.
Disability status**	N/A	Not applicable for eligibility into HUSKY B.

		See ** for HUSKY Plus eligibility criteria
Access to or coverage under other health coverage (Creditable coverage as defined in Federal law)	N/A	May not be covered at time of application or while active unless medical insurance coverage is minimal (e.g. coverage that only includes one or more of the following types of coverage; optometry, ophthalmology, dental, or prescription drugs). Children of any State or Municipal employees are barred from the program unless the employee was a municipal employee and dropped medical insurance due to extreme economic hardship as determined by the Department. In addition, children who had coverage in the last six months are not eligible unless the coverage was minimal, and or the coverage was dropped due to good cause as determined by the Department
Other standards (identify and describe): **<u>Citizenship Requirements</u>**	Medicaid citizenship requirements used including those from the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and the Balanced	Medicaid citizenship requirements used including those from the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and the Balanced

	Budget Act of 1997.	Budget Act of 1997.
Living Arrangement	N/A	Children must live with the applicant to be eligible except if the applicant is a non-custodial parent. Also, eligibility continues if the individual moves to an IMD.
Concurrent Eligibility	Individuals who are eligible for Title XXI in the State cannot concurrently receive Medicaid in the State.	Individuals who are eligible for Medicaid in the State cannot concurrently receive Title XXI in the State.

Footnotes:

****Countable income includes both earned and unearned income. Income which is excluded under federal law in the Medicaid program is excluded as countable income. The following deductions and disregards from countable income are also allowed:***
child support disregard, self employment expense deduction, personal employment expense deduction, day care expense deduction, and Plan for Achieving self-support (PASS) deduction. There also exists a State funded program for people with higher income.

*****The eligibility criteria for HUSKY Plus Behavioral (HPB): Children who have a DSM-IV diagnosis and have significant psychiatric and/or substance abuse problems, problems in daily functioning, and intensive service needs that cannot be met fully within the HUSKY B health plan. The eligibility criteria for HUSKY Plus Physical (HPP): Children enrolled in HUSKY B (income bands 1 & 2 only) who meet the definition of Children with Special Health Care Needs, which is as follows: Those who have or are at elevated risk for (biologic or acquired) chronic physical, developmental, behavioral, or emotional conditions and who also require health and related (not educational and not recreational) services of a type and amount not usually required by children of the same age.***

Section 3.1.2 How often is eligibility redetermined?

Table 3.1.2		
Redetermination	Medicaid Chip Expansion Program HUSKY A	State-designed CHIP Program HUSKY B
Monthly	No	No
Every six months	No	No
Every twelve months	Yes	Yes
Other	No	No

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v)

✓ Yes➡Which program(s)? Both HUSKY A and HUSKY B.

For how long? We offer 12 consecutive months of continuous eligibility (CE) for recipients under 19 years of age in both the HUSKY A and HUSKY B programs even if income increases during this period. If income decreases during a CE period while the client is receiving HUSKY B, the case will revert to either a lower income band within the HUSKY B program or, if necessary, the case will revert to the HUSKY A program. There is no limit to the number of CE periods that an eligible person may receive. We also offer 6 consecutive months of guaranteed managed care enrollment (GE) to all recipients of HUSKY A. Only one GE period may be given per an individual's lifetime.

3.1.4 Does the chip program provide retroactive eligibility?

✓ Yes➜Which program(s)?
How many months look-back?

Under the HUSKY A program, a 3-month retroactive period of eligibility is offered to any eligible child. The three month period is the three consecutive month period immediately prior to the date of application. Under the HUSKY B program, retroactive eligibility can only be offered to eligible newborn children retroactive to the date of the child's birth, only if an application is filed not more than thirty days following the birth of the newborn child.

3.1.5 Does the CHIP program have presumptive eligibility?

____ Yes➜Which program(s)?
Which populations?
Who determines?

✓ No

There is authorizing State legislation to offer presumptive eligibility to applicants for HUSKY A. To date, this option has not yet been implemented by the State.

3.1.6 Does your Medicaid program and CHIP program have a joint application?

✓Yes ➜ The State uses a joint application for Medicaid and CHIP.

✓No ➜ The joint application is not used to determine eligibility for other State programs.

3.1.7 Evaluate the strengths and weakness of your eligibility determination process in increasing creditable health coverage among targeted low-income children.

Strengths

Connecticut uses a single point of entry servicer (SPES) for applications. A toll-free number feeds directly into this location where applications can be prefilled with the assistance of a customer service representative. The prefilled application is then mailed to the client for signature and review. Upon receipt of the signed application, the SPES checks the department's existing eligibility management system (EMS) to determine if any of the household members are currently in receipt of Medicaid. If the case is either active Medicaid or appears to be HUSKY A Medicaid eligible, it is transferred to the appropriate Department of Social Services regional office for processing. Cases that appear to be HUSKY B eligible are retained by the SPES for processing and ongoing case maintenance. Throughout this process a revised, simplified, and shortened application form is used.

In addition to the application process being streamlined by use of a SPES and use of the shortened application, the verification process has also been streamlined. Clarification was issued to staff to reinforce the limited number of items that need to be verified. Of those items that need verification, verification is mostly self-

declared. When primary documents are needed, staff were advised to allow multiple types and forms of verification to help streamline the process and help remove barriers to eligibility.

The use of the SPES, the simplified application, and streamlined verification has increased the efficiency of our eligibility determination process and has resulted in an increase in creditable coverage among targeted low-income children.

Improvement Areas

The referral of cases between our HUSKY A and HUSKY B programs continues to present ongoing challenges. Our goal is to make eligibility for these two programs seamless. Towards this end, referral processes have been established for the identification and transfer of cases between the department and the SPES so that when eligibility for either HUSKY A or HUSKY B exists, clients are not required to reapply. More work is needed in this area. Ongoing training is being planned for staff, as well as the development of more automated tracking and referral processes to assist staff in identifying and transferring cases between programs more smoothly.

3.1.8 Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

Strengths

The Husky B redetermination process has been designed in such a way to help foster and promote increased creditable coverage to children. For example, the redetermination form is the same streamlined form used for the application process. It is prefilled prior to mailing, and the client is asked to only review and update the information for accuracy. The same verification method is used for the redetermination process as is used for the application process. Required verifications are minimal, with flexible options and alternatives offered to the client when source documents are needed. Both automated and manual referral processes have been developed to refer HUSKY B cases to the HUSKY A program at time of redetermination.

Improvement Areas

Improvement is needed and being planned in the HUSKY A redetermination process. Plans are underway to streamline the HUSKY A redetermination form

with the ability to prefill the redetermination as is done in the HUSKY B program.

The coordination of HUSKY A cases to the HUSKY B program is also being improved by ongoing efforts to generate automated lists of cases closed due to excess income to use for referrals into the HUSKY B program. Notice text on HUSKY A case closure notices is also being revised to advise clients of the availability of the HUSKY B program, as well as targeted mass mailings to inform HUSKY A clients who lose eligibility about the HUSKY B program.

3.2 What benefits do children receive and how is the delivery system structured? Section 2108(b)(1)(B)(vi)

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost-sharing (if any), and benefit limits (if any). **See Below**

Table 3.2.1 CHIP Program Type_____

Benefit	Is Service Covered? (T = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	T	None	
Emergency hospital services	T	$25 copayment unless it is determined to be an emergency in accordance with state law	$25 copayment waived if the patient is admitted
Outpatient hospital services	T	None	
Physician services	T	$5 copayment for outpatient physician services	
Clinic services	T	$5 copayment	
Prescription drugs	T	$3 copayment $5 copayment $6 copayment	Generics Oral contraceptives Brand Name
Over-the-counter medications	N		Some MCO's opt to offer this to their clients, but it is not a HUSBY B benefit

Outpatient laboratory and radiology services	T	None	
Prenatal care	T	None	
Family planning services	T	None	
*****Inpatient mental health services	T	None	60 day maximum exchangeable with alternate levels of care
*****Outpatient mental health services	T	1-10 covered at 100% 11-20 $25 copayment 21-30 lesser of a $50 copayment or 50%	Supplemental coverage available under HUSKY Plus
*****Inpatient substance abuse treatment services	T	None	Drug – 60 days Alcohol – 45 days
Residential substance abuse treatment services	N		
*****Outpatient substance abuse treatment services	T	None	60 visits per calendar year – Supplemental coverage available under HUSKY Plus
Durable medical equipment	T	None	With prior authorization
Disposable medical supplies	T	None	With prior authorization
Preventive dental services	T	None	

Restorative dental services	T	Limited benefit	Allowances for bridges/crowns; root canals; full or partial dentures or extractions, $50 per CE period with total limitation at $250 per CE period. For orthodontia: $725 allowance on an annual basis – client is responsible for remaining dollars
Hearing screening	T	$5 copayment	
Hearing aids	N		Available under HUSKY Plus
Vision screening	T	$5 copayment	
Corrective lenses (including eyeglasses)	T	Limited benefit	Allowance of $100 every 2 consecutive CE periods. In some certain situations, optical hardware is not a limited benefit, and the allowance limitations do not apply
Developmental assessment	T	None	
Immunizations	T	None	Periodicity schedule based on the American Academy of Pediatrics
Well-baby visits	T		
Well-child visits	T		
Physical therapy	T		Short term. Supplemental coverage available under HUSKY Plus
Speech therapy	T		Short term. Supplemental coverage available under HUSKY Plus
Occupational therapy	T		Short term. Supplemental coverage available under HUSKY Plus
Physical rehabilitation services	T		Short term. Supplemental coverage available under HUSKY Plus
Podiatric services	T	$5 copayment	

Chiropractic services	T	$5 copayment	
Medical transportation	T		Emergency transportation only, in accordance with state law definition of emergency
Home health services	T	None	With prior authorization
Nursing facility	T	None	With prior authorization
ICF/MR	N		
Hospice care	T	None	
Private duty nursing	N		
Personal care services	N		
Habilitative services	N		
Case management/Care coordination	N		
Non-emergency transportation	N		
Interpreter services	N		Not a covered benefit under HUSKY B, however, by contract the MCO's are required to have these services available to their enrollees
Other (Specify) Nurse Practitioners	T	$5 copayment	
Other (Specify) Naturopaths	T	$5 copayment	
Other (Specify) Nurse Midwives	T	$5 copayment	

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose “select” table.” Once the table is highlighted, copy it by selecting “copy” in the Edit menu and then “paste” it under the first table.

***** During FFY 1998-FFY 199 these limitations on mental health and substance abuse services were in place. Since January, 2000 HUSKY B has had mental health parity. Only mental retardation; learning, motor skills; communication and caffeine-related disorders; relational problems apply the noted limitations.

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.) See benefits chart detailed above.

The HUSKY benefit package includes preventive care, outpatient physician visits, prescription medicines, inpatient hospital and physician services, preventive services, outpatient surgical facility services, mental health and substance abuse services, short-term rehabilitation and physical therapy, skilled nursing, home health care, hospice care, diagnostic x-ray and laboratory, emergency care, durable medical equipment, eye care and hearing exams, and dental care. In addition, depending on the family income, many children will be eligible for HUSKY Plus, the special coverage option for children with intensive physical and behavioral health needs.

HUSKY B benefits combine the most generous benefits offered under the three state employee health plan options and includes comprehensive preventive services such as: well child and well baby care, dental, eye care and hearing exams. Supplemental coverage is available to children with special physical and behavioral health care needs in HUSKY Plus. HUSKY Plus extends the limits posed by HUSKY B or when services are not covered under HUSKY B benefit package.

Up to & including 185% FPL -	no premiums, no copayments
Over 185% FPL & up to and including 235% FPL -	no premiums, some copayments and eligible for HUSKY Plus
Over 235% FPL & up to including 300% FPL -	and monthly premiums of $30 for first child or $50/mo. family maximum, some copayments and eligible for HUSKY Plus

*Over 300% FPL	state negotiated premiums per child per month, some copayments and ineligible for HUSKY Plus

* The program for children in families with incomes over 300% is part of HUSKY B. It is not part of SCHIP.

Enabling services – At their own discretion, some MCO's may include non-emergency transportation and coverage of over-the-counter medications. MCO's must make translation services available to their clients and provide materials in English and Spanish, access to 24 hour care, assistance with appointment scheduling, assistance to disabled enrollees.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Table 3.2.3

Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* N/A
A. Comprehensive risk managed care organizations (MCOs)			
Statewide?	YES	YES	
Mandatory enrollment?	*	YES	
Number of MCOs	4 MCO's	3 MCO's	
B. Primary care case management (PCCM) program			
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)			

D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)	* • Birth to 3 • School Based Child Health (i.e., special education)	N/A	
E. Other (specify)			
F. Other (specify)			
G. Other (specify)			

*** Should be made available to the Medicaid expansion CHIP children.**

3.3 How much does CHIP cost families? See below.

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/copayments, or other out-of-pocket expenses paid by the family.)

___ No, skip to section 3.4

_X_ Yes, check all that apply in Table 3.3.1

Table 3.3.1			
Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
Premiums		X	
Enrollment fee			
Deductibles			
Coinsurance/copayments**		X	
Other (specify) _____			

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".
**See Table 3.2.1 for detailed information.

3.3.2 If premiums are charged: What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

Answer: Premiums are charged for families whose income falls between 235% and 300% of the FPL. The monthly premium amount is $30.00 for one child and $50.00 for two or more children. Premiums are collected by the managed care organizations on a monthly basis, however they do have the option of offering a less frequent collection schedule (e.g. quarterly, semi-annually) to their members, in addition to the monthly option. We

also have an option for families whose income is over 300% of the Federal Poverty Level. These families can purchase insurance with a State negotiated rate with the participating plans. The premiums per child are $137.38, $142.01and $200.20 depending on which plan the family selects. The option for families over 300% FPL is part of our HUSKY B program, but is not part of our SCHIP program.

If families in our SCHIP program fail to pay their premium, children become disenrolled from their managed care organization. The disenrollment occurs when the payment is more than 30 days overdue. The child is then locked-out for a 90 day period before re-enrollment can occur. The lock-out period can be shortened for good cause. Good cause can be established if the family can document either a decrease in family income or an unexpected catastrophic financial liability. Re-enrollment is contingent on the payment of the delinquent amount as well as pre-payment of the first month of coverage after the lock-out period.

3.3.3 If premiums are charged: Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

_X_ Employer
_X_ Family
_X_ Absent parent
_X_ Private donations/sponsorship
_X_ Other (specify) We have no restriction on who may assist the family with payment of the premium, except that, prior to the application of funds from a private organization, the MCO is required to request approval from the Department to guarantee equity and equal access by any enrollee for such application.

3.3.4 If enrollment fee is charged: What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

Answer: N.A.

3.3.5 If deductibles are charged: What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

Answer: N.A.

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

Answer: They are initially notified by the SPES at the time of eligibility grant, followed by monthly invoices and reminders from the managed care plan.

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

___ Shoebox method (families save records documenting cumulative level of cost sharing)
_X_ Health plan administration (health plans track cumulative level of cost sharing)
___ Audit and reconciliation (State performs audit of utilization and cost sharing)
___ Other (specify)_____

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

Answer: None

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

Answer: Two surveys have been conducted of families whose children were dis-enrolled due to non-payment of premiums. Of the 83 families surveyed, 24% had obtained other insurance and 23% said that they could not afford the premium. Another 47% were either experiencing billing problems; made late payments and were subsequently reinstated; or indicated that they had forgotten to mail payment.

3.4 How do you reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does your CHIP program(s) use?

The HUSKY Plan is supported by a multi-level public outreach campaign to inform parents about the availability of outstanding health coverage and urge them to take action to enroll their children.

HUSKY outreach is based on the following principles:

- Inclusive and collaborative.
- Mix of community-based and traditional public awareness/media marketing measures.
- Concise, understandable messages.
- Consumer-friendly.
- Cost-effective.
- Culturally competent and accessible to diverse constituencies.
- Appealing to children as well as adults when possible.

Under the twin banners of the HUSKY Healthcare Outreach Partnership and Covering Connecticut's Kids Coalition, this statewide outreach initiative is a cooperative effort of the Department of Social Services (DSS) and many health and human service organizations, including the Connecticut Children's Health Council and Children's Health Project; Benova Inc. (eligibility and enrollment contractor); Infoline (information and referral contractor); Connecticut Association for Community Action (CAFCA); and the legislature's Medicaid Managed Care Council's consumer access panel.

The crux of HUSKY outreach is a grass-roots approach. We bring information directly to parents at community meetings, fairs, events and worksite sessions. Just as often, HUSKY outreach brings the message to professionals who work with parents--the known and trusted people in health, education, human services and other fields who are already in the community who can vouch for the program and provide follow-up assistance.

Because HUSKY is a government-sponsored program, it is especially important that we access local community networks that already have the contacts and buy-in with parents. This helps cut through the stigma factor and provides on-scene application assistance to surmount such barriers as fears of immigrant parents about public charge.

By the same token, the wide, higher-than-usual income audience for CHIP indicates the need for commercial-like information materials and outreach approaches. These are parents who may have never enrolled a family member in a government program. For HUSKY (consolidating the Medicaid and CHIP target audience), the education and outreach measures range from printed brochures, flyers, information cards, posters and promotional items to radio advertisements, video presentations and professionally-designed website with email contact point. In the first half of calendar 2000, a TV advertisement and pilot billboards will begin.

Two cornerstones of public outreach are the DSS community-based outreach contracting initiative, currently providing $450,000 to ten outreach contractors; and the Covering Connecticut's Kids initiative, funded by the Robert Wood Johnson Foundation at approximately $644,000 and coordinated by the Children's Health Council. The DSS outreach contractors range from municipal health departments and local service agency collaboratives to community action agencies and school-based health centers. The RWJ Foundation-funded projects focus primarily on Connecticut's largest city, Bridgeport, and neighboring Stratford; and a diverse group of small cities and towns east of the capital city of Hartford.

The Connecticut Medical Outreach Model, funded by the HCFA fall 1999 outreach initiative with DSS, has brought HUSKY information and materials directly into the offices of several hundred Connecticut pediatricians. The project was generated in cooperation with the American Academy of Pediatrics' Connecticut chapter and the Yale Center for Children with Special Health Care Needs.

Full-time outreach staff work out of Benova, based in Farmington; CAFCA, based in Hartford; Children's Health Project (CHP), based in Hartford; and DSS, based in Hartford. Benova, CAFCA, CHP and DSS constantly deliver a wide range of community presentations, trainings and displays throughout the state, supplemented by part-time outreach services by regional Infoline child and maternal health liaisons. HUSKY outreach and application assistance is also conducted by over 20 Healthy Start contractors throughout Connecticut. College students on Infoline's summer staff have fanned out across the state to distribute posters and other materials in some of the hardest-to-reach, rural areas of the state.

In addition, the HUSKY Plan benefits from consumer outreach and information/referral by countless local agencies and entities which have no contractual or other formal relationship with DSS. These are the local schools, medical and health care providers, private and municipal health and social service departments, employers, federal agency branches, community-based organizations, child care centers and other child and family-oriented sites that have joined the HUSKY bandwagon for the benefit of the children and families they serve.

One ultimate indicator of outreach is receipt of applications. All told, applications have been generated for more than 38,100 children since Governor John G. Rowland opened the state's combined CHIP/Medicaid program in June 1998--more than 1,800 children's applications per month. This application total represents activity only at the program's single point of entry servicer (Benova); additional applications have been received directly at DSS field offices.

Table 3.4.1

Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Billboards	T	(starting)	T	(starting)		
Brochures/flyers	T	5	T	5		
Direct mail by State/enrollment broker/administrative contractor	T	(in process)	T	(in process)		
Education sessions						
Home visits by State/enrollment broker/administrative contractor						
Hotline	T	5	T	5		
Incentives for education/outreach staff						
Incentives for enrollees						
Incentives for insurance agents						
Non-traditional hours for application intake	T	5	T	5		
Prime-time TV advertisements						
Public access cable TV	occasional	Interview shows 4		4		
Public transportation ads						
Radio/newspaper/TV advertisement and PSAs	T	5	T	5		
Signs/posters	T	4	T	4		
State/broker initiated phone calls(follow-up to applications)	T	4	T	4		
Other (specify)						

Other (specify)						

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

3.4.2 Where does your CHIP program (s) conduct client education and outreach?

Client education and outreach is conducted in a huge variety of locations throughout Connecticut by HUSKY's extended network of outreach partners. Training and presentations are provided during the business day, evenings and on weekends, including outreach to minority and community groups that make up Connecticut's diverse population. Following is a sample of some of the more unusual examples:

- Training of counseling staff at two correctional facilities, including the state's prison for women, with focus on reaching parents leaving the system and rejoining their children.

- Funding of health outreach staff member at non-profit summer camp sponsored by state's largest newspaper.

- Professional representation of HUSKY directly in pediatricians' offices through HCFA/DSS-funded pilot.

- Presentations to parents being laid off due to business closings as part of the state Department of Labor's rapid-response team.

- Special training for Judicial Department, Family Support Magistrates, Attorney General's Office and DSS child support enforcement staff to fulfill legislation requiring magistrates to require applications for HUSKY when insurance is not otherwise available.

- Training curriculum for child care providers enrolled in Connecticut's professional development program for child care; and information to child care providers statewide, including production of 9-minute introductory videotape about HUSKY, specifically targeted to child care providers.

- Expansion of regional 'coaches' campaign' to reach athletic directors, coaches, student-athletes and, ultimately, parents about availability of HUSKY.

- Presentations to grandparent support groups to reach family members who have become legal guardians.

- Training of outreach health workers of Connecticut River Valley Farm Worker Health Program.

- Training of educational/social service staff of Connecticut Indian Affairs Council, representing the state-recognized tribes.
- Production of short video and collateral items targeted to teenagers.
- Translation of HUSKY fact sheets into ten languages.
- Training of statewide administrators of Boy and Girl Scouting, and leaders and scouts of some individual troops.
- Recruiting teenage HUSKY peer counselors as a pilot in a major urban high school (Bulkeley High, Hartford).

Table 3.4.2

Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Battered women shelters	T	2	T	2		
Community sponsored events	T	5	T	5		
Beneficiary's home						
Day care centers	T	5	T	5		
Faith communities	T	3	T	3		
Fast food restaurants	T	3	T	3		
Grocery stores	T	3	T	3		
Homeless shelters						
Job training centers	T	5	T	5		
Laundromats	T	2	T	2		
Libraries	T	5	T	5		
Local/community health centers	T	5	T	5		
Point of service/provider locations	T	5	T	5		
Public meetings/health fairs	T	4	T	4		
Public housing	T	3	T	3		
Refugee resettlement programs	T	5	T	5		
Schools/adult education sites	T	5	T	5		
Senior centers	T	5	T	5		
Social service agency	T	5	T	5		

Workplace	T	5	T	5		
Other (specify)						
Other (specify)						

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

Notes: Some of the above sites for outreach have been covered on a regional or local basis, depending on the focus of individual outreach contractors and other service providers. The rating scale is necessarily subjective because of the complexities of directly attributing hotline calls and applications to specific outreach activities, as outlined in the accompanying text.

3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population.

Connecticut shares the frustration of other states in the challenge of zeroing in to evaluate specific outreach measures. In general, the difficulty results (ironically) from the large scope of outreach activities. Because so much is going on, people may hear about HUSKY from various sources. They may see a poster, hear an ad on the radio, hear about it from a friend or school nurse and, finally, take action to call the HUSKY hotline. It can be hard to pin down the triggering source.

As the effects of outreach build cumulatively, this dynamic will probably increase; that is, more outreach, more word on the street, less specificity about the source of knowledge and call to action. Another factor is that we don't want our call centers to spend inordinate time cross-examining parents about where they heard about HUSKY as much as getting quickly to the point of the call.

With that caveat as background, we do take steps to track outreach measures and trends. While many outreach steps are broadly targeted (radio and print advertisements and brochures, for example), others are more precisely trackable. So, while the largest category by far of 'how callers heard about HUSKY' is the catch-all 'friend/family/word of mouth' (1,131 calls in last half of calendar 1999 at HUSKY Health Infoline), we can directly attribute 134 calls to an information card sent by the Department of Motor Vehicles in car registration renewal notices. Information provided through schools is consistently the second-highest reason for calling (542), followed by Department of Social Services; flyer/brochure/poster; newspaper/magazine/phonebook; doctor; and clinic/hospital.

The HUSKY hotline branch at Benova, our eligibility/enrollment contractor, reports 'friend' as top calling reason (325 from mid-October 1999 through February 2000), followed by '[medical/health] provider's office'; 'food pantry'; 'DSS worker'; 'relative/family member'; and 'hospital/clinic.'

Some of the call tracking results are surprising. Radio, for example, was cited for only 96 calls over six months at HUSKY Health Infoline, despite ads on several stations, while TV (where there has been occasional publicity and cable information but no paid ads so far) drew 165 calls at

Infoline and 52 calls at Benova. Fairly consistent print ads in Spanish-language and community publications drew almost 300 calls to Infoline, while some 600,000 flyer inserts in the Hartford Courant resulted in 300-400 returned coupons for more information.

The message may be that prominent ads in small but closely-read local papers are sometimes more effective than mass-circulated but less prominent ads buried in large Sunday papers. However, it is also important for new health programs to try as many publicity angles as possible.

General awareness of HUSKY is fairly strong for a new program, and growing. The Connecticut Children's Health Council commissioned a survey/poll of HUSKY awareness in January and February 2000 by the University of Connecticut Center for Survey Research and Analysis. Among respondents with children under 18 (the basic target audience), the survey reported that 61% have heard about the HUSKY Plan. In the polling field, this is regarded as a positive result, especially for a relatively new program. The leading sources of information about HUSKY cited by the 1,112 respondents were attributed to newspapers (37%); TV or radio (32%), and relatives or friends (15%). These percentages do not coincide with the call center tracking results, perhaps underscoring the elusive nature of outreach evaluation in general.

A series of four focus groups conducted in mid-1999 by the Connecticut Health Policy Project, funded by DSS, gave some interesting findings. Children of most participants were Medicaid-eligible, rather than CHIP-eligible, and selection of participants was based on getting people whose children were not enrolled in HUSKY. A prevalent theme was that parents are still learning about HUSKY ("the word is not out to everyone."). Several parents had heard about the program from "diverse media sources, but either didn't pay attention or didn't understand that the program could help their families. Many parents who did know about HUSKY learned about it from a neighbor, friend, health care or child care provider."

Participants cited stigma and suspicion of public coverage as a barrier for some families. They also emphasized the need for culturally sensitive services, both in outreach and program enrollment. HUSKY's main color brochure was well-received, although some parents in one focus group said it looked like "you are trying to sell me something." While this may have been a backhanded compliment, it's a good point that locally-produced materials can resonate in the community; in fact, several DSS contractors have distributed grass-roots pamphlets, doorknob cards and other items. We believe that an effective approach at the community level is to pair the

statewide HUSKY hotline number with information on how to contact a local HUSKY outreach representative agency.

The focus group report found that "enrolling children in health coverage is not as simple as sending out brochures and waiting for clients to apply. In many cases, enrollment is a complex process involving information, advocacy, application assistance, follow-up and sometimes persuasion…some parents are baffled by the health care landscape in general, and may confuse HUSKY with news and advertising 'noise' about commercial products. Some may need to hear about it from a trusted member of the community, and some may need to hear from several sources before they take action."

While parents in the focus groups generally liked the outreach brochure and application, most "would appreciate having someone in-person to ask questions."

The need for continual attention to using locally-based strategies to weave HUSKY into the fabric of communities was supported by the largely African-American focus group in Bridgeport. "There were many comments that implied or explicitly stated that the reason people have not signed up for HUSKY is because the state has not 'come to the community'." Bridgeport, ironically, has been a leading source of HUSKY applications but the above statement might be telling in the sense that enrollment of African-American children has not kept up with the pace of Hispanic-Latino and Caucasian children.

The evaluation implications for outreach from the four focus groups of most non-member families include attention to cultural barriers; breaking through the stigma and suspicion of public programs; expanding the HUSKY message to further emphasize working families; further enlisting non-traditional messengers; and continuing the volume of information to reach people who either haven't heard about HUSKY or who have heard about it but have not taken action to enroll their children.

Currently, lists of HUSKY enrollments by town are compiled and distributed to outreach organizations as a way to monitor activity. A future hope for evaluation and tracking is implementation of a geographical information system (GIS) for HUSKY. GIS systems are used by corporations, police departments, land management agencies and others to track and monitor activities over time. Such a system would enable us to track activity and trends of hotline calls, applications and enrollments from each municipality in Connecticut across a timeline. The program would

have better intelligence about where to target specific outreach measures and broader campaigns. DSS has entered into discussions with the state Department of Information Technology about developing a GIS system for HUSKY.

In evaluating outreach nationwide, the basic question seems to be: what works best and what doesn't? Like other states, Connecticut is using a wide variety of outreach, training, education and consumer information techniques. It can be difficult to validate or eliminate a technique simply because a consistently large number of calls can or cannot be attributed to it.

Some of the most enlightened outreach projects are not documented successes in terms of generating applications. A recent partnership with Kmart and Martha Stewart Living Omnimedia is directly credited with only 24 hotline calls and 13 applications but also helped boost public awareness and undoubtedly had a greater effect than the numbers indicate (of course, an activity is probably worth doing if even a few parents apply for their children). Parents may store information in the back of their minds and take action later without telling the program where they first heard about it or what tipped the scales to make them apply. This blurring effect of what actually causes parents to take action is something that may fade in time as states gain more experience with outreach.

The nebulous category of positive word-of-mouth seems to be most successful outreach indicator, judging from our call center reports. Advocacy and help in getting people to call a hotline and fill out and send an application with income verification is critical in many cases. But, again, it is difficult to isolate one particular outreach technique as optimum because there are so many factors in prompting the action to call and apply, just as there are so many factors in following through with the application, verification and enrollment process. It is probable that the work of many individual outreach activities is actually reflected in the word-of-mouth category, too.

Like other states, we recognize that outreach through the schools must be a centerpiece of spreading public awareness and encouraging application and enrollment. Much of our training and material distribution is aimed at school nurses, social workers, food service administrators (linkage with free and reduced-price school lunch program), guidance counselors and, to a lesser extent, administrators and teachers. Hotline call counts attributed to school outreach are usually the second-highest.

In terms of general analysis of why CHIP enrollments are not keeping pace with Medicaid enrollments in Connecticut, the following points may be helpful:

- Stigma factor—long cited as a deterrent to Medicaid enrollment but now less prevalent with warmer program imagery and customer service, the stigma factor is nonetheless very real for HUSKY B. Some parents do not want to get involved in a 'government' program. Anecdotally, some parents have told Benova staff to wipe their names out of the computer as soon as they learned HUSKY was government-run. Many parents have never applied for a government-sponsored program before and do not intend to now. This suspicion of public programs occurs despite herculean efforts to present HUSKY as an exciting new commercial-like product.

- Cost-sharing—for many families, the notion of paying premiums for HUSKY coverage is a positive thing, even lessening the stigma factor. However, we lose some children because parents don't keep up with premiums. We also lose children because some parents never start paying premiums. We probably also lose children because some parents aren't willing to pay the higher premiums in 'income band 3'—the group rate category for families over 300% of the federal poverty level. HUSKY does not have a process of payroll deduction with employers. For some parents, writing the premium check each month does not remain a priority, especially if children are healthy.

- Strength of Connecticut's economy—it is possible that employer-sponsored dependent care—good, bad or indifferent--at the higher income levels is more prevalent than anticipated. If parents are not flocking to HUSKY B, many may have alternatives in the workplace. For many families, these alternatives are not necessarily great coverage of choice, however, which brings us to the complexities of 'crowd-out.'

- Crowd-out—the requirement that public health insurance programs like HUSKY should not crowd out, or supplant, employer-sponsored coverage is certainly understandable in global terms. On a practical level, however, crowd-out requirements can have a chilling and confusing effect on enrollment. Some parents may not recognize that crowd-out applies only to employer-sponsored coverage, not privately-purchased coverage. Many parents have fairly expensive and weak coverage for children through work. Some employers offer a program for convenience but don't contribute to it. Crowd-out's six-month waiting period deters applications for many children who are essentially underinsured in general and actually uninsured in some areas (dental, for instance). The eligibility exceptions to crowd-out are hard to communicate. Crowd-out may be a shield against employers dropping their

coverage plans, but many of these plans can't compare with HUSKY benefits and costs. So, in a way, crowd-out is a shield against children getting an outstanding benefits package that parents can afford.

- Newness of the program—even though HUSKY B is over 20 months old, it is still new by the standards of commercial products and government programs. As noted, our call centers consistently note that word of mouth is the top referral source for parents. Just about every major decision people make is based in some part on word of mouth. The ripple effect of positive word of mouth can't be overestimated and does not happen overnight. We've had parents tell us that they just heard about HUSKY from a friend or relative and can't believe it's here; it's 'too good to be true.' They may not have responded to a pamphlet, flyer or advertisement or another measure that may have caused other people to take note. And, as with just about any product, people usually have to hear a message multiple times before it resonates and they take action.

- Enrollment barriers—HUSKY is distinguished by a customer-friendly gateway: toll-free hotline, application-by-phone option, customer service representatives available after hours and on Saturday, even a colorful website. However, we are still working to smooth out enrollment barriers, chiefly in the area of cohesion between HUSKY A and B when children leave HUSKY A. A transparent referral to HUSKY B, making it as easy as possible for the parent to understand the transition from Medicaid to CHIP, is the goal.

  Additionally, we are further simplifying the HUSKY application and working to ensure that all notices are user-friendly, commercial-like and unbureaucratic. These and other measures to eliminate any 'hassle factor' are especially important to combat stigma concerns.

- History of health and human service community providers serving HUSKY A market—the existing health care service infrastructure naturally tilts toward the HUSKY A market when it comes to public outreach. For decades, the focus was getting kids into Medicaid. The advent of HUSKY B means that public, private and municipal health and human service staff have to re-tool and broaden their messages and market. We expect this factor to be mitigated in time as the relatively new DSS community-based outreach initiative continues, and by the Governor's budget proposal to consolidate outreach dollars.

- Top HUSKY myth—unfortunately, the myth that HUSKY is a 'welfare' program is still out there. For the HUSKY B market especially, any hint of welfare and public assistance can overshadow the facts. As a focus group

report noted, we must continue to emphasize that HUSKY is for working families of all income levels.

- Top HUSKY B myth—the above, and 'I know about HUSKY and it looks good but my child wouldn't be eligible because of our income.' The HUSKY B audience can exclude their own children, thinking that their income level doesn't ever qualify them for anything. This is why our general outreach message stresses that if your child 'doesn't have health insurance, give us a call.' For most uninsured children, it's not a matter of whether HUSKY is for them but what part of HUSKY is for them.

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

A central principle of HUSKY outreach is a culturally competent and inclusive approach. DSS and our partner agencies continually offer and deliver presentations and trainings to organizations that serve varying ethnic populations and, often, the parents directly. Presentations are delivered in Spanish when appropriate. At least one HUSKY outreach contractor is retaining a Portuguese-speaking staff member.

Key materials, such as the main marketing brochure and application, are distributed in Spanish text. A HUSKY general information flyer is offered in Spanish, Albanian, Arabic, Bosnian, Haitian/Creole, Kurdish, Loatian, Polish, Portuguese and Vietnamese. A flyer with questions and answers for immigrant families is offered in multiple languages. Special efforts are made to ensure that photos and graphics in materials represent diverse populations.

Cultural diversity awareness training for outreach staff has been organized t the Hartford-based Hispanic Health Council, while the Bridgeport-based International Institute of Connecticut has helped outreach programs with translation and other communication support, including legal expertise regarding public charge and other immigration-related issues. Hotline call center staff have in-house Spanish-language capacity and also have access to ATT Language Link for extensive translation needs.

DSS has invested in significant advertising through radio and newspapers serving the Hispanic-Latino and African-American communities. The community media list includes:

- InnerCity News (New Haven/Bridgeport/Waterbury)

  - Umoja News (Bridgeport)
  - InTouch News (Bridgeport)
  - Northend Agents (Hartford)
- Hartford Inquirer
- Bridgeport Inquirer
- New Haven Inquirer
- The Observer (Middletown)
- West Indian American News (Hartford)
- El Tiempo (Meriden)
- El Extra (Hartford)
- Panorama (Hartford)
- Connecticut Hispanic Yellow Pages
- Selected published programs for special events, such as Hispanic Health Council annual health fair and annual events by the state African-American Affairs Commission and Latino and Puerto Rican Affairs Commission.
- La Voz de Hispana de CT (New Haven/Bridgeport/Stamford)
- Connecticut Woman magazine
- To I Owo (Polish-language, New Britain/Middletown)
- Ilm, magazine for New England Muslim community
- WCUM, Spanish-language (Bridgeport)
- WRYM, Spanish-language (Newington)
- WLAT, Spanish-language (Hartford)
- WPRX, Spanish-language (New Britain)
- WNEZ, African-American (Hartford)
- WKND, African-American (Hartford)
- WYBC, African-American (New Haven)
- Telewizja/Polski Express (TV, planned)
- CimaTV (Spanish-language, Bridgeport, planned)
- WRDM-TV13 (Spanish-language, Hartford, planned)

Periodically, we partner with a community radio station or publication to present HUSKY information and application assistance at local festivals in a co-sponsorship role.

Presentations have been made to the Connecticut Indian Affairs Council, a federally-funded organization that provides social, educational, housing and other services to tribal members; the Eastern Pequot Indians of Connecticut; the Mashantucket Pequot Tribal Nation; and the Mohegan Tribe. We also consulted with the federally-recognized Mashantucket Pequot Tribal Nation and the Mohegan Tribe in accordance with the State Plan.

Staff of the Connecticut River Valley Farm Worker Health Program have been trained about HUSKY availability and services. Direct outreach to some tobacco farm workers and farm owners was included.

Presentations at places of worship have centered on African-American churches. This form of outreach is exceptionally labor-intensive, with the Sunday hours challenging even the routine alternate-hour outreach schedules and with clergy understandably wanting to approve the message before it is delivered. At times, clergy themselves volunteer to deliver the HUSKY message.

The ongoing schedule of HUSKY outreach speaking and fair/event presentations includes minority communities statewide. These presentations are done by DSS, Benova Inc., Infoline, Children's Health Project, Connecticut Association for Community Action, and our contracted agencies, as well as outreach collaboratives funded under the Robert Wood Johnson Foundation/Covering Connecticut's Kids initiative.

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

As outlined in section 3.4.3 above, evaluation of success of individual outreach activities is a difficult area. And, with the growing recognition that application assistance needs to be an integral part of outreach for many parents, even the methodology of defining success can be elusive. For example, on one level an outreach activity might be judged successful if it sparks a telephone call to the consumer call center. However, if the parent does not follow up with completing an application, the end result is zero.

On another level, outreach might be judged successful if an application assistance component, such as an outreach-affiliated local agency, is part of the outreach service and a completed application is smoothly filed. In this model, we could judge the outreach to be successful by not only sparking a call to the hotline but by helping and encouraging the parent through the application and enrollment process—and being there to answer questions and advocate along the way.

In Connecticut, outreach is evolving in the direction of the combined information provision/application assistance model, within the constraint of available funding.

But it is still difficult to measure the success of individual outreach measures because of the dynamics outlined above and more fully in section 3.4.3.

We strongly believe that the grass-roots focus of HUSKY outreach is especially critical when reaching diverse communities. Many parents, especially newcomers to the United States, do not trust or understand the "government." As noted in the Connecticut Health Policy Project focus group report, "Parents need an ongoing source of accurate, user-friendly information and support during the application process and beyond. This source of information must be a trusted part of their community…"

Connecticut is on the right track by using what the Children's Health Council calls the 'key informant' training model of public education, as the Children's Health Council calls it. This model delivers information to groups and individuals having regular contact with parents and children. By involving community-based organizations, schools, employers that do not provide dependent care benefits, and so on, in the outreach and education effort, we foster a network of HUSKY ambassadors and a ripple effect throughout the community. At the same time, various outreach steps directly reach parents in a community, often through sponsorship of a local organization.

According to the recent poll/survey by the University of Connecticut Center for Survey Research & Analysis (see section 3.4.3), awareness "differences associated with age, race/ethnicity, and educational attainment were not significant." While this may be heartening to some extent, we are also concerned about the number of enrollments of minority children. For example, in HUSKY A (Medicaid and CHIP-funded Medicaid expansion), the net increase of enrollment over an 18-month period finds African-American children (1,608) well behind Hispanic-Latino (4,393) and Caucasian (6,840) children, according to statistical analysis by the Children's Health Council.

In HUSKY B (CHIP), the enrollment breakdown is currently is at 3,484 Caucasian children; 592 Hispanic-Latino; 520 African-American; 92 Asian; 13 Native American; 6 Pacific Islander; and 399 unknown (applicants are not required to provide race/ethnicity information).

While enrollment proportions are not directly attributable to outreach because of program enrollment factors, parental follow-through and the other reasons discussed above, they are useful in defining the need in various communities and the urgency of directing outreach to specific

populations. That is why, for example, DSS continues to advertise and seek news coverage in minority publications and on radio, and why we are planning TV ads and PSAs on Spanish- and Polish-language programming. It's also why the HUSKY outreach partner agencies continue to plan, solicit and deliver presentations and training in local community settings.

Outreach for children with special health care needs is spear-headed by the HUSKY Plus program centers which are the Center for Children with Special Health Care Needs at Connecticut Children's Medical Center; the Center for Children with Special Health Care Needs at Yale; and the Yale Child Study Center. The HUSKY Plus program centers work closely with the HUSKY B managed care plans to best identify and refer special needs children who may benefit from referral to HUSKY Plus. This includes a direct mailing to parents of all children enrolled in HUSKY B. The program centers also work with advocacy groups and providers of goods and services in an attempt to get the word out about the availability of the HUSKY Plus program. In addition, the Department and the centers widely distribute a booklet with basic information about HUSKY Plus, which includes the program centers' names, addresses, and direct telephone numbers.

The goal of these and other outreach measures is to make sure that the HUSKY program reaches entire potential population of HUSKY Plus eligibles. Because this target population is more narrow than the overall HUSKY audience, outreach must be more specific. We encourage referrals to HUSKY Plus from multiple sources, including self-referrals, referrals from health plans, referrals from medical providers, and referrals from HUSKY Plus centers themselves if they receive calls directly.

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

Table 3.5

Type of coordination	Medicaid* HUSKY A	Maternal and Child Health Programs	Program for Special Needs Children	Other State/Public Agencies serving Children
Administration	X (1)	X (9)	X (13)	
Outreach	X (2)	X(10)	X (14)	X (15)
Eligibility determination	X (3)	X (11)	X (13)	
Service delivery	X (4)		X (13)	
Procurement	X (4)			
Contracting	X (4)	X (9)		
Data collection	X (5)	X(9,12))	X(13)	
Quality assurance	X (6)	X (9,12)	X (13)	
Other (specify) Enrollment Broker	X (7)			
Other (specify) Medical Necessity	X (8)			
Other (specify) Access measures	X (8)			
Other (specify) Appeal Process				X (16)

*Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

Connecticut's SCHIP State Plan is a combination program consisting of a Medicaid expansion (HUSKY A) and a separate, state-designed CHIP program (HUSKY B). In addition, the state-designed CHIP program includes a supplemental program for

children with special medical and behavioral health needs (HUSKY Plus). Table 3.5 Notes describes the coordination among HUSKY A, HUSKY B and HUSKY Plus plans as well as with other health care and non-health care programs in the State.

Coordination with Medicaid (HUSKY A)

(1) Key state administrative staffs have responsibility in both HUSKY A and HUSKY B in the areas of eligibility, health plan enrollment, MCO marketing, quality assurance and finance.

(2) Connecticut conducts a combined approach to outreach activities targeting populations eligible for HUSKY A, HUSKY B and HUSKY Plus. The Department of Social Services (DSS) outreach staff, the Single Point of Entry Servicer (SPES)/enrollment broker, the HUSKY Plus contractors, the HUSKY InfoLine, the State's outreach grantees, and the Robert Wood Johnson Foundation "Covering Kids" grantee meet on a quarterly basis throughout the year to discuss best practices, concerns and methods to better coordinate outreach efforts. (For further details on outreach coordination, please refer to the Outreach section of this document)

(3) Coordination in eligibility determination occurs at the point of application, health plan (managed care organization) enrollment and redetermination. There is a single application form for both HUSKY A and B. The SPES screens for HUSKY A eligibility and refers appropriate cases to the HUSKY A eligibility staff. A DSS eligibility expert is co-located at the SPES to facilitate an efficient and effective referral process for initial applications and redetermination forms from the SPES to the Medicaid eligibility offices.

(4) HUSKY services are delivered through contracts with managed care organizations (MCOs). HUSKY A has four participating MCOs and HUSKY B has three. All of the HUSKY B MCOs participate in HUSKY A, a factor that minimizes disruption in care for members moving from HUSKY A to B or from HUSKY B to A due to changes in program eligibility. Administrative burdens to the MCOs and the State are also lessened by the overlap of participating MCOs in HUSKY A and B. Key administrative staffs in procurement and contracts are responsible for HUSKY A, HUSKY B and HUSKY Plus contracts.

(5) Key administrative staffs in HUSKY A and B coordinate eligibility and enrollment statistical data with the SPES for administrative management and federal reporting purposes.

(6) Key administrative staffs have responsibility in HUSKY A, HUSKY B and HUSKY Plus for quality assurance standards, reports and the external quality review organization (EQRO) contract. HUSKY A and HUSKY B MCOs share a

significant number of the same reporting requirements and measures concerning the delivery of care to their members. The reporting requirements are based on either NCQA HEDIS measures, modified HEDIS or state-designed measures. All three programs are subject to an annual EQRO evaluation. Connecticut contracts with the same EQRO for all three programs, a factor that results in a modest economy of effort for the MCOs, the State, and the EQRO. (For further details on quality assurance and access, please refer to the Quality Assurance and Access sections of this document)

(7) Connecticut's Single Point of Entry Servicer (Benova) is also contracted to act as the enrollment broker for both HUSKY A and HUSKY B. As such, access to health plan information for members who are moving between the two programs is simplified through the same entity and dedicated telephone line.

(8) Connecticut requires the MCOs to apply the same definition of "medical necessity" and the same access standards for HUSKY A and HUSKY B services provided to the respective members.

Coordination with Maternal and Child Health Programs

(9) HUSKY A contracts require the MCOs to coordinate activities with such state agencies as the Departments of Children and Families, Education, Public Health, Mental Health and Addiction Services and Mental Retardation. Coordination with such programs as WIC, Birth to Three, Healthy Start, Healthy Families and others is accomplished through memoranda of understanding formulated and agreed to by the MCOs and parent agencies. MCOs must contract with the Connecticut Immunization and Registry Service (CIRTS) to track childhood immunizations of children in managed care and report on data and with School-based Health Centers (most are funded by DPH, the MCH agency) for primary and preventive care services as well as the range of services provided by clinical practitioners recognized by the NCQA. These contractual requirements are facilitated through the effective coordination and cooperative relationships between the Department of Social Services and the other state agencies involved. (For a description of coordination in HUSKY B, please refer to the column entitled "Programs for Special Needs Children".)

(10) Outreach grantees include the WIC sites, School-based Health Centers, Federally Qualified and Community Health Centers funded by the State's Department of Public Health, which is the lead agency for Title V and Maternal and Child Health grants.

(11) Prior to the implementation of HUSKY, the State had a health care program for children, Healthy Steps. This program was eliminated legislatively and subsumed

under the HUSKY Plan. The transition of Healthy Steps clients was coordinated between the Departments of Public Health, the MCH lead agency, and Social Services, the Medicaid/SCHIP agency.

(12) HUSKY A and HUSKY B adopted the immunization standards and schedule based on the ACIP standards, as modified and issued by the State's Department of Public Health (DPH). Connecticut has a universal access immunization program. In addition, the EPSDT periodicity schedule in HUSKY A was developed based on the AAP Guidelines, and in coordination with DPH and the participating MCOs. HUSKY B adopted the same schedule for its Well Child visits.

Coordination with Programs for Special Needs Children

(13) HUSKY B includes HUSKY Plus, a supplemental program for children with intensive physical health and/or behavioral health conditions whose needs cannot be met within the basic benefit package offered in HUSKY B. The HUSKY Plus program consists of two parts: HUSKY Plus Physical and HUSKY Plus Behavioral. Both programs have Steering or Advisory Committees composed of parents of children with special needs, representatives from the HMO Association, and state agencies that serve children with special health care needs.

For HUSKY Plus Physical (HPP), the State contracts with the two Title V providers, namely the Connecticut Children's Medical Center and the Yale Center for Children with Special Health Care Needs, to administer the program. The Departments of Public Health, the MCH lead agency, and Social Services, the Medicaid/SCHIP agency, collaborate as principal co-chairs of the HUSKY Plus Physical Steering Committees along with the two centers. Representatives from the Departments of Mental Retardation, Children and Families, Education, Insurance and the Office of the Child Advocate provide the expertise and perspective of such programs as the state's Birth to Three and School-based Child Health. In addition, HPP medical eligibility criteria, benefits, providers, quality measures and reporting are based on the Title V program.

For HUSKY Plus Behavioral (HPB), the State contracts with the Yale Child Study Center to administer a supplemental behavioral health benefit package. HPB determines medical eligibility for the program and delivers services through child guidance centers, which are also traditional Medicaid/HUSKY A providers of behavioral health services for children.

Key administrators, advocates and agency representatives of the HUSKY Plus Steering Committees are also members of the Connecticut Medicaid Managed Care Council or its subcommittees. The Council is a broadly constituted body formed by Connecticut’s General Assembly and having oversight of

Connecticut's Medicaid Managed Care Program. HPB administrators and providers are also grantees of the Department of Children and Families (DCF), the state's lead mental health agency for children and Title IV-E agency. The Yale Child Study Center and HPB are also members of DCF Advisory Committee, which advises DCF on behavioral health issues. (For a description of coordination in HUSKY A, please refer to the column entitled "Maternal and Child Health Programs.")

(14) The HUSKY Plus programs conduct outreach to potential medically eligible children through their involvement in the overall HUSKY outreach efforts. In addition, HPP and HPB conduct targeted training with the SPES, the contractor which determines eligibility for HUSKY B and enrolls children in MCOs for both HUSKY A and HUSKY B, the HUSKY B MCO staffs, as well as individual providers and specialty provider associations.

Coordination with other state agencies or public organizations serving children

(15) HUSKY B staff participates in statewide committees and special task forces of agencies such as the Office of the Child Advocate, the Family Support Council and the Connecticut River Valley Farmworkers Health Program. These activities afford us an opportunity not only to disseminate information about Connecticut SCHIP and to represent the interests of the HUSKY B enrollees, but also to hear the concerns Connecticut's families have about health care for children and to be in the forefront as issues develop.

(16) Appeals from MCO decisions regarding the provision of goods and services are first addressed to the MCO and then to the Connecticut Department of Insurance (DOI), following the model for such appeals in commercial managed care. DOI is the lead agency for commercial (i.e., non-governmental, non-ERISA) managed care plans in Connecticut.

3.6 How do you avoid crowd-out of private insurance?

6 month waiting period for children with private insurance.

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

_____ Eligibility determination process:

_X_ Waiting period without health insurance (specify) – 6 month waiting period if employer sponsored insurance was dropped.

_X_ Information on current or previous health insurance gathered on application (specify) – yes, this information is obtained on the application
_X_ Information verified with employer (specify) - our enrollment broker will spot-check this information with the employer
___ Records match (specify)
___ Other (specify)
___ Other (specify)

___ Benefit package design: See chart above in Section 3.2.1

_X_ Benefit limits (specify): See chart above in 3.2.1
_X_ Cost-sharing (specify): See chart above in 3.2.1
___ Other (specify)
___ Other (specify)

___ Other policies intended to avoid crowd out (e.g., insurance reform):

___ Other (specify)
___ Other (specify)

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

Crowd-out is very difficult to monitor. We do not verify with every employer when employer-sponsored insurance was dropped. There is some spot-checking by our enrollment broker on applications being sent in. 20% of the applications approved per month is spot-checked by the enrollment broker. Exceptions to our crowd-out provision include: loss of employment, death of a parent, termination of dependent coverage, change of employer, self-employment, extreme economic hardship or any other reason determined by the department to be unrelated to the availability of HUSKY B, etc.) Information about exceptions to crowd-out are sent to families who currently have insurance or had insurance over the last six months when they are sent a letter of denial for the program Families can file for an exception and are encouraged to do so. We are finding that this is not happening that often. Additionally, according to the advocates the six-month waiting period is having an impact on families with special needs children. These are the children that cannot go without medical insurance for any length in time. There is interest by the Department in eliminating the six month rule for special needs children and allowing children with household incomes above 300% FPL to participate in the HUSKY Plus Program.

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

Who enrolled in your CHIP Program?

4.1.1 What are the characteristics of the children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i)

***Table 4.1.1 CHIP Program Type*: SCHIP**

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Year end enrollees as percentage of unduplicated enrollees per year	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	894	5,281	1.4	6.3	98.2%	71.9%
Age						
Under 1	29	159	1.2	5.8	96.6%	85.5%
1-5	249	1,450	1.5	6.2	99.2%	72.3%
6-12	383	2,220	1.4	6.4	97.7%	72.6%
13-18	233	1,452	1.4	6.2	98.3%	68.9%
Countable Income Level						
185 - 235% FPL	594	3,498	1.4	6.5	98.8%	73.2%
236 - 300% FPL	300	1,783	1.4	6.0	97.0%	69.4%
Age and Income						
Under 1						
185 - 235% FPL	20	112	1.3	5.8	95.0%	85.7%
236 - 300% FPL	9	47	1.1	5.7	100.0%	85.1%
1-5						
185 - 235% FPL	168	980	1.5	6.3	99.4%	73.8%
236 - 300% FPL	81	470	1.5	6.2	98.8%	69.4%
6-12						
185 - 235% FPL	261	1,446	1.4	6.7	98.5%	73.4%
236 - 300% FPL	122	774	1.5	5.9	95.9%	71.2%
13-18						
185 - 235% FPL	145	960	1.5	6.4	99.3%	70.8%

236 - 300% FPL	88	492	1.3	5.8	96.6%	65.0%
Type of plan						
Fee-for-service	0	0	-	-	-	-
Managed care	894	5,281	1.4	6.3	98.2%	71.9%
PCCM	0	0	-	-	-	-

a. Connecticut began reporting S-SCHIP data in Quarter four, FFY 1998; therefore data for FFY 1998 data are only partial year.

*Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly Report instructions for further details.

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

Answer: In FFY 98 165 CHIP enrollees had access to health insurance and in FFY 99 1,049 CHIP enrollees had access to health insurance, prior to enrollment in CHIP. This information was obtained from the HUSKY application.

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

Answer: N.A.

4.2 Who disenrolled from your CHIP program and why?

4.2.1 How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

Answer: 1,681 disenrolled from the HUSKY B program. The rate of SCHIP disenrollment is slightly less than that of traditional Medicaid.

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP?

Answer: 333 children did not re-enroll in HUSKY B. At least 12 of these children obtained other insurance. Please note that since these families did not comply with their annual review, it is not fully known how many obtained other insurance.

4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

Table 4.2.3

Reason for discontinuation of coverage	Medicaid CHIP Expansion Program** **This information is not available at this time. However, as soon as it is available, it will be sent		State-designed CHIP Program		Other CHIP Program* *These numbers represent the families over 300% of FPL. This is not a CHIP program	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total			1,681	100%	158	100%
Access to commercial insurance			470	28.0	40	25.3
Eligible for Medicaid			206	12.3	0	

Income too High						
Aged out of program			63	3.7	0	
Moved/died			1	.1	0	
Nonpayment of premium			421	25.0	84	53.2
Incomplete documentation			103	6.1	1	.6
Did not reply/unable to contact						
Other (specify)			77	4.6		
Did not reapply At redet			333	19.8	10	6.3
Don't know						

*Make a separate column for each other program identified in section 2.1.1. To add a column to a table, right click on the mouse, select insert and choose column.

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

Answer: Several efforts are underway to outreach to families with children who are still eligible to re-enroll: 1) A mass mailing is being done targeting children who lost eligibility for reasons other than aging out of the program, death, or loss of Connecticut residency. Families of these children are being encouraged to reapply if their child still needs medical coverage; 2) Text has been added to the Medicaid discontinuance notices to advise caretakers that the child may continue to be eligible for HUSKY. Caretakers are encouraged to call and reapply for HUSKY; 3) A weekly roster of newly created HUSKY A spenddown cases will be supplied to the SPES for granting of HUSKY B; eligibility and 4) Outreach workers are encouraging caretakers to reapply and supplying them with information needed to make the re-application process proceed smoothly.

4.3 How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 -0-

FFY 1999 $18,897,990

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

Table 4.3.1 CHIP Program Type ___HUSKY A-Medicaid Expansion___				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures		14,718,651		9,567,125
Premiums for private health insurance (net of cost-sharing offsets)*		10,923,675		7,100,389
Fee-for-service expenditures (subtotal)				
Inpatient hospital services		1,179,347		766,576
Inpatient mental health facility services		198,017		128,711
Nursing care services		300		195
Physician and surgical services				
Outpatient hospital services				

Outpatient mental health facility services				
Prescribed drugs		36,455		12,696
Dental services		42,727		27,773
Vision services				
Other practitioners' services		640,349		416,227
Clinic services		89,706		58,309
Therapy and rehabilitation services				
Laboratory and radiological services		15,129		9,834
Durable and disposable medical equipment				
Family planning				
Abortions				
Screening services		11,403		7,412
Home health		342,968		222,929
Home and community-based services		161,951		105,268
Hospice		62,741		40,782
Medical transportation				
Case management		60,338		39,220
Other services		953,545		619,804

Table 4.3.1 CHIP Program Type _HUSKY B-SCHIP_				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures		4,179,339		2,716,570
Premiums for private health insurance (net of cost-sharing offsets)*		4,179, 339		2,716,570
Fee-for-service expenditures (subtotal)				
Inpatient hospital services				
Inpatient mental health facility services				
Nursing care services				
Physician and surgical services				
Outpatient hospital services				
Outpatient mental health facility services				
Prescribed drugs				
Dental services				
Vision services				
Other practitioners' services				
Clinic services				

Therapy and rehabilitation services				
Laboratory and radiological services				
Durable and disposable medical equipment				
Family planning				
Abortions				
Screening services				
Home health				
Home and community-based services				
Hospice				
Medical transportation				
Case management				
Other services				

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category. **$27,345**

What types of activities were funded under the 10 percent cap? **Staff & related activities**

What role did the 10 percent cap have in program design? **__none___**

Table 4.3.2						
Type of expenditure	Medicaid Chip Expansion Program		State-designed CHIP Program *		Other CHIP Program* _____	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share						
Outreach						
Administration				27,345		
Other_____						
Federal share						
Outreach						
Administration				17,774		
Other __ _____						

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

X State appropriations
___ County/local funds
___ Employer contributions
___ Foundation grants
___ Private donations (such as United Way, sponsorship)
___ Other (specify) _____

* These numbers include the administrative costs for Medicaid CHIP expansion and the separate CHIP program.

4.4 How are you assuring CHIP enrollees have access to care?

4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify delivery system (Section 3.2.3), if approaches vary by type of system within each program. For example, if an approach is used in a managed care organization, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in a primary care case management program, specify 'PCCM.'

Table 4.4.1

Approaches to monitoring access	**Medicaid CHIP Expansion Program (HUSKY A)**	**State-designed CHIP Program (HUSKY B)**	**Other CHIP Program: HUSKY Plus**
Appointment audits	MCO	MCO	NA
PCP/enrollee ratios	MCO	MCO	NA
Time/distance standards	MCO	MCO	FFS[1]
Urgent/routine standards	MCO	MCO	FFS
Network capacity reviews (rural providers, safety net providers, specialty mix)	MCO	MCO	FFS
Complaint/grievance/disenrollment reviews	MCO	MCO	FFS
Case file reviews	MCO	MCO	FFS
Beneficiary surveys	MCO	MCO	NA
Utilization analysis (emergency room use, preventive care use)	MCO	MCO	FFS
Other (specify) Operational Audit	MCO	MCO	FFS
Other (specify) Special Studies	MCO	NA	FFS
Other (specify) Customer Service Hotline	MCO	MCO	FFS

Please refer to Section 4.6 for a copy of reports currently available as related to Connecticut's processes to monitor and evaluate access to care by CHIP enrollees.

[1] Connecticut contracts with HUSKY Plus administrators that in turn pay their providers on a fee-for-service basis.

4.4.2 What kinds of managed care utilization data are you collecting for your CHIP program(s)? If your state has no contracts with health plans, skip to question 4.4.3.

Table 4.4.2			
Type of utilization data	**Medicaid CHIP Expansion Program (HUSKY A)**	**State-designed CHIP Program (HUSKY B)**	**Other CHIP Program: HUSKY Plus**
Requiring submission of raw encounter data by health plans	_X_ Yes ___ No	___ Yes _X_ No	NA
Requiring submission of aggregate HEDIS data by health plans	_X_ Yes ___ No	_X_ Yes ___ No	NA
Other (specify) Aggregate state-designed	___ Yes _X_ No	___ Yes _X_ No	_X_ Yes_ No

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

During the reporting year, Connecticut completed numerous surveys and utilization data reports on the Medicaid expansion, CHIP and HUSKY Plus population. The summarized results of these activities are provided in Appendix 4.6.

4.4.4 What plans does your CHIP program(s) have for future monitoring/evaluation of access to care by CHIP enrollees? When will the data be available?

In addition to the effective and comprehensive monitoring already described in sections 4.4 and 4.5, Connecticut is in the process of developing new surveys, utilization data reports and special studies. We contracted with an EQRO to conduct special studies on access and quality of care. This report is scheduled to be completed by December 31, 2000.

4.5 How are you measuring the quality of care received by CHIP enrollees?

4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with repect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in a primary care case management program, specify 'PCCM.'

Table 4.5.1

Approaches to monitoring quality	**Medicaid CHIP Expansion Program (HUSKY A)**	**State-designed CHIP Program (HUSKY B)**	**Other CHIP Program: <u>HUSKY Plus</u>**
Focused studies (specify)	MCO	MCO	FFS
Client satisfaction surveys	MCO	MCO	NA
Complaint/grievance/disenrollment reviews	MCO	MCO	FFS
Sentinel event reviews	MCO	MCO	FFS[2]
Plan site visits	MCO	MCO	FFS
Case file reviews	MCO	MCO	FFS
Independent peer review	MCO	MCO	FFS
HEDIS Performance measurement	MCO	MCO	NA
Other performance measurement (specify)	See Table 4.4.1	See Table 4.4.1	See Table 4.4.1

[2] Connecticut contracts with HUSKY Plus administrators that in turn pay their providers on a fee-for-service basis.

4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

During the reporting year, Connecticut completed numerous quality of care reports on the Medicaid expansion, CHIP and HUSKY Plus population. The summarized results of these activities are provided in Appendix 4.6.

4.5.3 What plans does your CHIP program(s) have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will the data be available?

In addition to the effective and comprehensive monitoring already described in sections 4.4 and 4.5, Connecticut is in the process of developing new surveys, utilization data reports and special studies. We contracted with an EQRO to conduct an independent peer review and special studies on access and quality of care. This report is scheduled to be completed by December 31, 2000.

4.6 Please attach any reports or other documents addressing access, quality, utilization, costs,
satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.

Access and Quality Document Inventory		
Medicaid CHIP Expansion Program (HUSKY A)	**State-designed CHIP Program (HUSKY B)**	**Other CHIP Program: HUSKY Plus**
Utilization	Utilization	Utilization
EPSDT (Child health screening)	Well Child Visits	HUSKY Plus Behavioral Activity Report
Preventive Care	Children's Access to Primary Care Providers	HUSKY Plus Physical Activity Report
Immunization	Immunization Status of Two Year Olds	HUSKY Plus External Quality Review[3]
Prenatal/Maternal Care	Dental Services	Administrative Review
Inpatient	Prenatal/Maternal Services	Case file review
Emergency Room	Ambulatory Care	Site visit
Other Services (dental, prescribed drugs, substance abuse, vision, transportation)	Inpatient	Medical and Administrative Review focused on Cystic Fibrosis.
Mental Health Overview	Emergency Care	Medical and Administrative Review focused on Cerebral Palsy.
Mental Health Inpatient	Outpatient Drug Utilization	Medical and Administrative Review focused on Major Depression.
Mental Health Re-admissions	Mental Health Inpatient Discharges/ALOS	HUSKY Plus Program Reports
Substance Abuse Overview	Mental Health Inpatient/Ambulatory	HUSKY Plus Behavioral Annual Program Report
Substance abuse Inpatient	Follow up after Hospitalization for Mental Illness	HUSKY Plus Physical Annual Program Report

[3] The External Quality Review of the HUSKY Plus programs was completed in March 2000. The final report will be available at a later date.

Access and Quality Document Inventory		
Medicaid CHIP Expansion Program (HUSKY A)	**State-designed CHIP Program (HUSKY B)**	**Other CHIP Program: HUSKY Plus**
Substance Abuse Re-admissions	Chemical Dependency Inpatient Discharges/ALOS	
	Chemical Dependency Inpatient/Ambulatory	
External Quality Review	External Quality Review (due 12/2000)	
Administrative Review	Administrative Review	
Case file review	Case file review	
Site visit	Site visit	
Focused Studies		
Pediatric Asthma Project		
Encounter Data Validation Report		
Net Enrollment Report (by county, by MCO)	Net Enrollment Report (by county, by MCO and by premium band, by MCO)	
Disenrollment by Reason Report	Disenrollment by Reason Report	
Grievances Report	Benova: Complaint Report	
Primary Care Provider/Enrollee Ratio	Primary Care Provider/Enrollee Ratio (Uses HUSKY A as proxy)	
Provider Network Capacity	Provider Network Capacity (Uses HUSKY A as proxy)	
Client Satisfaction Surveys	Client Satisfaction Surveys	
Survey of Children with Special Health Care Needs[4]	Benova: HUSKY B Customer Satisfaction Survey	
CAHPS [5]	InfoLine: Survey of	

[4] Scheduled to occur in Spring 2000.

Access and Quality Document Inventory		
Medicaid CHIP Expansion Program (HUSKY A)	**State-designed CHIP Program (HUSKY B)**	**Other CHIP Program: HUSKY Plus**
	Families with Children enrolled in HUSKY B	
Behavioral Health Outcomes Study[6]		

[5] MCOs are currently planning to conduct for December 2000 and will include HUSKY A and B enrollees.
[6] The study design for this HUSKY A project is currently in the final planning stage. The study design will be made available by June 2000. The study is scheduled to begin in July 2000.

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work.

Connecticut's Goal: We are very proud that the overall goal of HUSKY is health insurance availability for <u>every</u> child in Connecticut. Our Medicaid and SCHIP programs cover children in families with incomes up to and including 300% of the federal poverty level and our state-funded HUSKY B program covers uninsured children in families with incomes over 300% of the federal poverty level.

5.1.1 Eligibility Determination/Redetermination and Enrollment

<u>Eligibility Determinations</u>:
Connecticut has streamlined its application process through the use of a single and simplified application for HUSKY A and B and through its contracted Single Point of Entry Servicer (SPES).

The initial single and simplified application removed many barriers to the application process. It was an excellent first step. We have since revised the application which, once field-tested, will be released. We believe this new version further simplifies and, at the same time, clarifies the questions being asked.

The SPES was established to pre-screen for HUSKY A and B and to smooth out the application process by allowing applications to be accomplished in a variety of ways. Mail-in applications are accepted by the SPES for both HUSKY A and B. Clients can also apply by telephone (asking questions throughout the application process) and the SPES will send the pre-filled printed application to the client for review, verification, signature, and return.

When an application is received by the SPES, it will be screened. If the family appears to be HUSKY B eligible, the SPES will review the

application in more depth and make a determination of eligibility. If the family appears to be HUSKY A eligible, the SPES will transfer the case to the HUSKY A eligibility specialist out-stationed in their office. This person is a Department of Social Services (DSS) employee who specialized in eligibility determinations in the regional office before being assigned to work at the SPES. This DSS eligibility specialist reviews the potential HUSKY A application in depth. If the family is HUSKY A eligible, the case is forwarded to the appropriate regional office for the final, official review of eligibility. The families are not required to personally appear at either the SPES or the Department's regional office. There were a few problems in the beginning with inappropriate referrals being made by the SPES to the regional office. Since we placed a DSS HUSKY A eligibility specialist at the SPES in the latter part of CY 1998, the problems have been reduced significantly.

It is important to note that families are not precluded from applying in person to a regional office of DSS. If a family applies to the regional office, that office will review the case for HUSKY A eligibility. If the family is eligible, there is no need to send the case to the SPES. The regional office will only send the case to the SPES if the family appears to be eligible for HIUSKY B. We have had some problems with the referral of those cases found not eligible for HUSKY A being transferred to the SPES for a determination of HUSKY B eligibility. Some clients have simply been told they are not eligible for HUSKY A with no mention of the possibility of HUSKY B, leaving these families without any health insurance coverage for the children at all. The Department has been working hard to correct this problem through better notification letters and additional training of the regional office staff. While not completely resolved, we are doing better.

Neither HUSKY A nor B requires a financial assets test and many of the documentation requirements that were a standard part of the application process in the past have now been eliminated. Advocates would still like us to lessen our income verification requirements and we have discussed this option.

DSS regional office staff administer a wide variety of programs with different eligibility standards. The existence of another health insurance coverage option (HUSKY B) adds complexity to the breadth of knowledge that our regional staffs must master. In an effort to address our concern regarding the number of programs each worker must be knowledgeable about, there has been some discussion of centralizing eligibility

determinations for children's health coverage or of appointing specialized eligibility workers at the regional offices.

Redeterminations/Renewals:

The HUSKY B redetermination process has been designed in such a way to help foster and promote increased creditable coverage to children. For example, the redetermination form is the same streamlined form used for the application process. It is prefilled with the information used in the original eligibility determination. The client is asked to review the form for accuracy, update the information if necessary, provide the required verifications, sign the form and return it. Required verifications are minimal, with flexible options and alternatives offered to the client when source documents are needed. Even so, we have had some HUSKY B families ask why their eligibility should be reassessed on an annual basis, since this is not done in commercial health insurance.

Redeterminations are handled very much like original applications. When the SPES receives returned forms they screen for HUSKY eligibility in either A or B. If it's a B case, they keep it and finish the redetermination process. If it appear to be an A case, the out-stationed DSS worker reviews it and when appropriate, refers it to the regional office. Similarly, HUSKY A redeterminations are reviewed in the regional offices and if it is an A case, the eligibility process is completed there. If the family's income has risen and eligibility in HUSKY A is lost, the case is sent to the SPES for a HUSKY B eligibility determination. Like our problems with initial applications going from the regional offices to the SPES, we have had a problem here. We are working on resolving this problem.

Enrollment:

Enrollment in a managed care plan is done by the SPES for both HUSKY A and B. We have found this system works extremely well.

In HUSKY B, the cut-off date for enrollment in an MCO for the first of the month, is the 15th of the previous month. This is a crucial date for HUSKY B families since HUSKY B is entirely a managed care program and there is no fee for service as there is in HUSKY A. It has been suggested that we revisit this cut-off date, especially for families who are discontinued in HUSKY A and must now move into HUSKY B. If a gap in eligibility occurs, this gap results in a gap of coverage. The Department will be looking into this possibility.

Enrollment in an MCO in the HUSKY B program requires the family to choose an MCO. There is no default enrollment as there is in HUSKY A. At present, the HUSKY B program requires that families provide a signed form indicating their choice of MCO. We are looking into the possibility of allowing HUSKY B families to call in their enrollment choice, which would facilitate actual enrollment.

5.1.2 Outreach

Connecticut is in step with the federal mandate to seek out children who have no health insurance coverage, educate families about the availability of SCHIP and Medicaid programs, and make entry into the programs as barrier free as possible.

As an initial step, Connecticut decided to use the umbrella name of HUSKY for both its Medicaid program for children (HUSKY A) and its new SCHIP program (HUSKY B). We market both programs together as HUSKY. The focus is on children who are uninsured, not on children within certain income levels who are uninsured. We believe this lessens the stigma for recipients of HUSKY A. The downside to having a single name is confusion between the two programs. Clients already on Medicaid apply for HUSKY thinking it is a different program and some clients do not know if they are in HUSKY A or HUSKY B (although eligibility notification letters make this clear and MCO member cards show the particular program). Even with the possible confusion, we believe this umbrella approach is a good one.

Using an umbrella name allows us to have one brochure for the HUSKY program, one logo, one CT-HUSKY toll free telephone line, application entry for all potential HUSKY applicants through the SPES (although applications could come through the regional offices), one Web page, and one design for our give-away items (which are useful and attractively colored items such as pencils, pens, rulers and magnets).

Before SCHIP, DSS's experience had been mostly with families who have few financial resources. Our outreach efforts reflect this – we have been successful in reaching families in the lower income brackets. Children are coming into HUSKY A at a rate of about three times that of children coming into HUSKY B. We need to re-evaluate our outreach efforts for the families within higher income brackets in order to better reach families whose children would be eligible for HUSKY B. Our Child Support unit would like to be more involved with the outreach effort and this

collaboration could assist our efforts to reach additional families since the Child Support unit has clients in a wide variety of income brackets.

Connecticut has contracts with a number of community based organizations for outreach. Many of these contractors have been successful in reaching additional children. Some of these contractors are focusing solely on children in the lower income brackets. While it is very important to reach these families, we believe families with higher incomes need to be aggressively sought out also. DSS is working on developing a clearer message and better training for our outreach contractors (concerning the target audience, eligibility and benefits), devising a method for better monitoring the outreach contractors and ensuring better statewide coordination of outreach efforts amongst outreach contractors, and developing performance measures and an objective evaluation process for the contractors.

Because Connecticut's HUSKY A program includes families with income up to and including 185% of the federal poverty level, HUSKY A (like HUSKY B) is for working families. We need to make sure this message gets out. Neither HUSKY program should be equated with welfare and the stigma that goes with it. All of HUSKY is for uninsured children of working families.

There is some disappointment in the advocacy community that we have not been able to more closely coordinate with various school programs in getting the word out on HUSKY. We have coordinated fairly extensively with school nurses and social workers, but getting HUSKY information out with applications for school lunch programs and asking parents about their child's health insurance coverage on medical examination forms has not happened. We continue to work with the Connecticut Departments of Education (SDE) and Public Health (DPH) on these issues.

Other possibilities for working with other agencies abound and continue to be explored by DSS outreach staff. We work closely with DPH on a number of issues and outreach opportunities. The Commissioner of SDE has supported our outreach efforts through superintendents of schools, school nurses, and other school staff. The Connecticut Department of Revenue Services has sent out HUSKY information with their tax packages since the spring of 1998 and the Department of Motor Vehicle has sent out HUSKY information with their car registration renewal notices. The Department of Labor contacts us when companies or organizations are planning to lay off employees or close and then we provide on site information about HUSKY, along with printed educational material and

applications. These companies/organizations have included private hospitals, small manufacturing plants, and even the Federal Deposit Insurance Corporation. We continue to explore outreach opportunities with other Connecticut agencies and federal agencies such as Housing and Urban Development and the Internal Revenue Service.

The DSS outreach staff also provides briefings and printed material and applications to part-time workers at the request of private companies. As we are becoming better and better known, more of these requests have come in.

Outreach is an educational opportunity. Health insurance, as opposed to urgent care, is important. We need to get the message out to families that preventive health care for children is necessary, and health insurance coverage not only allows preventive care, but also facilitates it through requirements of MCOs to monitor well-child visits and aggressively seek out families whose children are not getting preventive care.

5.1.3 Benefit Structure

The benefit package for HUSKY B is extremely generous, including dental and mental health benefits. Pursuant to Connecticut statute, HUSKY B now has full mental health parity. For children coming onto the program, there are no pre-existing condition exclusions.

There is excellent supplemental coverage for children who have intensive physical and/or behavioral needs through the HUSKY Plus programs. These programs are available to children enrolled in HUSKY B whose family income does not exceed 300% of the federal poverty level. Enrollment in both HUSKY Plus Physical (HPP) and HUSKY Plus Behavioral (HPB) is lower than we had expected. This may be due to the fact that the basic HUSKY B benefit package is so generous and that eligibility for HUSKY A (Medicaid) is and has been very broad, especially for children with special health needs.

HPP has 69 children enrolled. This program is joined with the Title V, Children With Special Health Care Needs (CSHCN), program sponsored by DPH. We have worked closely with DPH over the last two years expanding the definition of children who have special health care needs, clarifying the role of the Steering/Advisory Committee, defining the appeals process, evaluating the clinical eligibility tools, and reviewing forms. This program has been very labor-intensive throughout the first two

years. With much of the basic work behind us now, we are hoping the program will require less hands-on work by HUSKY B staff.

Enrollment in HPB is 6 children. We do not know why HPB has excessively low numbers. It may be that the low enrollment is a function of the extremely generous HUSKY B benefit package. Connecticut recently completed a comprehensive study of publicly sponsored children's behavioral health services. The report, "Delivering and Financing Health Services in Connecticut" is attached. Recommendation has been made to develop an integrated behavioral health service delivery system for children and youth with serious emotional disturbances who are presently eligible to receive services from HUSKY A, HUSKY B, HPB, and voluntary services operated by the Department of Children and Families. We are working with Connecticut legislators to make this recommendation a reality.

5.1.4 Cost-Sharing

Many HUSKY B services are subject to co-payments, but there are no co-payments for preventive care. For enrollees whose families have an income of over 185% FPL and up to and including 235% FPL, there are no premiums required. For families with an income of over 235% FPL and up to and including 300% FPL, the premiums are $30 per month for one child or $50 per month total for more than one child. Our co-payments and premium share are low compared to commercial health insurance, especially in light of the very generous benefit package. In addition, there is a maximum annual aggregated cost-sharing limit for families, which is within the federally mandated five percent cap. We believe sharing in the financial cost of the insurance emphasizes responsibility on the part of the parent and reduces the stigma of being on a state-sponsored program for many families.

Two surveys have been conducted of families whose children were disenrolled due to non-payment of premiums. Of the 83 families surveyed, 24% had obtained other insurance and 23% said they could not afford the premium. Another 47% were either experiencing billing problems; made late payments and were subsequently reinstated; or indicated that they had forgotten to mail the payment.

While we have continuous eligibility for a year, if a family's income drops and they report that to the SPES, we will move the children to a less expensive income band of HUSKY B or into HUSKY A within the continuous eligibility period, if the family qualifies for the change.

5.1.5 Delivery System

HUSKY B is a managed care program. It does not have default enrollment, as does managed care in HUSKY A. Requiring the family to choose a managed care plan emphasizes choice and responsibility. If the family does not choose a plan within ninety days, the eligibility of the children will be lost. The family can reapply.

Continuous eligibility for a year provides stability during periods of fluctuating income, although families whose income goes down, can be placed in a less expensive income band of HUSKY B or go into HUSKY A if the new, lower income warrants the change. Some families have complained that they do not want to undergo annual redetermination, claiming that commercial insurance does not require it.

Like most states, Connecticut has problems with a lack of participating dentists in the managed care plans and therefore in the program. We continually work on this problem.

5.1.6 Coordination with Other Programs

Private Insurance:
HUSKY B staff has worked closely with insurance agents who are members of the Connecticut chapter of the National Association for the Self-Employed. We have provided brochures and applications and briefed member agents on the program. In turn, these agents have helped us spread the word on HUSKY to their clients, many of whom cannot afford to purchase private insurance for their children or who only have access to limited health insurance for their children.

Crowd-Out:
Connecticut's crowd-out provision prohibits eligibility for the HUSKY B program if the child's family or employers of the parents have discontinued employer-sponsored dependent coverage within the last six months for the purpose of participation in the HUSKY B program. There are several exceptions such as loss of employment due to factors other than voluntary termination, death of a parent, and termination of dependent coverage due to an extreme economic hardship.

When an application is reviewed by the SPES and the child either is presently insured or had employer-sponsored insurance within the last six months, the SPES has been sending the family a letter of denial for the

program along with information about the crowd-out exceptions and how to appeal in case one of the exceptions is applicable. We are looking into the feasibility of sending a letter requesting more information, rather than a denial letter, in hopes that the families might be more apt to file for an exception and their children then would have a greater chance of becoming eligible.

Crowd-out appears to be more of a federal concern than a state concern. It works to the disadvantage of responsible parents who bought what health insurance they could get before the HUSKY B program began, and now cannot have their children qualify for HUSKY B without a six-month lapse in insurance coverage for their children. There are some exceptions to the six-month rule, but overall this requirement interferes with covering more children under the HUSKY B program.

This six month time period is especially harsh for families with special needs children. The risk of going without health insurance is difficult for any family, but for those families with special needs children, the risk is impossible to take. There is some interest in pursuing the possibility of eliminating the six-month waiting period after employer-based insurance is dropped if the child for whom the application is made is a child with special health care needs.

HUSKY A & B:
Th combined application and the pre-screening of applications by the SPES requires coordination amongst DSS central office HUSKY A staff, HUSKY B staff, DSS regional staff, and the SPES. There have been some problems with smooth coordination, but problem areas have been identified and solutions are in place or are being worked on for the future. Similarity in benefits package and managed care plans and their responsibilities requires coordination between DSS central office HUSKY A staff and HUSKY B staff in managing their contracts with the MCOs. Since these staffs are co-located on the same floor within the central office, coordination is frequent and problem areas smoothed out early in the process.

HUSKY B and the HUSKY Plus programs:
There has been very frequent coordination, through the formal Steering/Advisory Committee process and through less formal meetings and telephonic and electronic communications, between the HUSKY B staff and the HUSKY Plus center staffs. Within the Steering/Advisory Committees for these programs, HUSKY B staff work with program staff from other Connecticut agencies, such as the Department of Public Health,

Department of Mental Retardation, the Department of Children and Families, the Department of Education, and the Office of the Child Advocate, thereby coordinating, on a policy level, with programs run by these other agencies.

HUSKY Plus Physical and Title V:
A close working relationship has developed between the HPP DSS staff and the Title V DPH staff. We have had numerous meetings to discuss covered services, authorization procedures, operating guidelines and protocols for the HPP Steering/Advisory Committee and subcommittees, and the development and revision of forms used jointly in our programs.

Child Advocate's Task Force:
HUSKY B staff has worked with the Office of the Child Advocate, policy makers, public and private agencies and health care providers to review how Connecticut cares for children with special health needs/developmental disabilities.

5.1.7 Evaluation and Monitoring

There is a legislative and HUSKY staff commitment to evaluation and monitoring of the SPES, managed care plans, and the HUSKY Plus centers. Advocates would like the same monitoring of HUSKY B as there is of HUSKY A. This would include monitoring in a public forum like the Medicaid Managed Care Advisory Council, which meets monthly to discuss the HUSKY A program.

There has been close HCFA oversight of all the CHIP programs through the annual reports due each year and the state evaluation due this year, in addition to site visits and periodic requests for information. The necessary responses to these forms of oversight require significant staff time.

HCFA's requirement for unduplicated count of enrollees since inception of program was difficult to produce for our Medicaid CHIP expansion (which is a small part of our HUSKY A program), especially because of additional Y2K requirements due at the same time. This problem has been resolved.

5.1.8 Full Buy-In Option

Connecticut has a buy-in option for families whose income is over 300% FPL. Connecticut is committed to providing access to health insurance for all children. We believe this buy-in option also helps to reduce the stigma of state-sponsored health insurance programs since eligibility and

enrollment into HUSKY is not tied to a low income. In fact, it is not tied to income at all.

5.2 What plans does your State have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))

5.2.1 Integrated Behavioral Health Service Delivery System

As discussed in section 5.1.3, above, Connecticut is working to develop an integrated behavioral health service delivery system for children and youth with serious emotional disturbances who are presently eligible to receive services from HUSKY A, HUSKY B, HUSKY Plus Behavioral, and voluntary services operated by the Department of Children and Families. We are also studying both an employee buy-in option for dependant coverage and a joint purchasing initiative between HUSKY A, HUSKY B and state employees' health insurance.

5.2.2 Possible Employer Buy-In to HUSKY B

Connecticut is exploring the possibility of designing a program that would not only meet the needs of the State, but would also comply with the Health Care Financing Administration's requirements for a premium assistance program under an employer-sponsored group health plan. Connecticut currently has a low unemployment rate; however, even when insurance is offered through an employer, the insurance option is not always utilized, particularly for dependent coverage (unemployed spouse and children). This is due largely to the cost to the employee.

5.3 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

5.3.1 The ten percent cap on administrative expenses

The ten-percent cap on administrative spending is unreasonable and should be eliminated or increased significantly. States are asked to perform a multitude of tasks with their administrative funds, especially in extensive evaluation and outreach.

5.3.2 Crowd-out

As stated above, crowd-out seems to be more of a federal concern than a state concern. We believe each state should have significant flexibility in the design of a program that will work best for it. Although the crowd-out

provision was not specific at the start-up of CHIP, it was understood that states should have a significant crowd-out policy in place. In fact, the proposed federal regulations now call for a six-month crowd-out provision. Although Connecticut already has a six-month provision, we believe reducing the amount of crowd-out time or designing other strategies to prevent substitution of coverage, would better serve the children of Connecticut.

5.3.3 Screening for Medicaid

The federal statute prohibits children who are eligible for Medicaid from being placed in the SCHIP program. This prohibition requires screening for Medicaid (our HUSKY A) eligibility first, which necessitates numerous questions on our application. We believe that the Medicaid screening requirement makes the eligibility process for HUSKY B far more complicated than it needs to be.

5.3.4 Ineligibility if a child is in an IMD/Continuity of Care issues

Title XXI excludes from the definition of "targeted low-income child" a child who is a patient in an institution for mental disease (IMD). This has been interpreted to prohibit eligibility to a child who is a patient in an IMD at the time of the initial eligibility determination or any subsequent redeterminations.

The IMD exclusion runs contrary to mental health parity, continuity of care responsibility, and overall good medical care for the child. If a child is on the CHIP program and is placed in an IMD just prior to his annual eligibility redetermination, that child will loose eligibility and be taken off CHIP. If the same child was an inpatient at a medical hospital he would not loose coverage. Application of the Title XXI statute and HCFA policy requires states to discontinue health insurance coverage for a child just at the point when the child most needs it.

Connecticut requires its managed care organizations (MCOs) to continue to provide coverage for an inpatient hospital stay up to the point of discharge for any enrollee who was admitted as an inpatient under such MCO, even when that enrollee is disenrolled from the MCO. The MCO's responsibility for the inpatient hospital stay is the same whether the child is hospitalized for a physical or mental illness. Application of the federal statute and policy results in a situation where the government refuses to accept the responsibility for continued care for the child (because that child

is in an IMD) but requires the MCO to continue its responsibility even after eligibility for the program (and thus the capitation payment) ends.